HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
SEPTEMBER 24, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	Vanderbilt University Hospitals
PROJECT NUMBER:	CN1406-021
ADDRESS:	1211 Medical Center Drive Nashville (Davidson County), Tennessee 37232
LEGAL OWNER:	Vanderbilt University Hospitals 1211 Medical Center Drive Nashville (Davidson County), Tennessee 37232
OPERATING ENTITY:	Not Applicable
CONTACT PERSON:	Ginna Felts (615) 936-6005
DATE FILED:	June 12, 2014
PROJECT COST:	$118,276,950
FINANCING:	Cash Reserves and Tax-Exempt Bonds
PURPOSE OF REVIEW:	Modification of a hospital requiring a capital expenditure greater than $5 million and the addition of 108 licensed beds.

DESCRIPTION:

Vanderbilt University, by and through its Vanderbilt University Medical Center, owns Vanderbilt University Hospital (VUH), the Monroe Carell Jr. Children's Hospital at Vanderbilt (MCJCHV), and the Psychiatric Hospital at Vanderbilt (VPH). All three facilities are operated under one license as Vanderbilt University Hospitals and are known collectively as Vanderbilt University Medical Center. This application seeks to modify and add beds to both VUH and MCJCHV. The project includes approximately 79,783 square feet of renovation, 126,686 square feet of new construction, and the addition of 108 licensed beds. The facilities will be modified as follows:

MCJCHV-Three previously approved floors (CN710-075AE) will be built out to accommodate the relocation of the obstetrical program, the newborn nursery and the neonatal unit currently located in VUH; the addition of 23 obstetrical beds; and the addition of 24 neonatal/pediatric critical care beds.

VUH-The space vacated in VUH due to relocations to MCJCHV will be renovated to accommodate the addition of 61 adult acute care inpatient beds. Other areas in VUH (North, South, East Towers and The Vanderbilt Clinic) will be renovated to accommodate a total of 63 observation beds which are not licensed beds.

The project does not involve the initiation of new health care services or acquisition of major medical equipment. At completion, the hospital will be licensed for 1,159 beds. The estimated project cost is $118,276,950.00.

CRITERIA AND STANDARDS REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. **For renovation or expansions of an existing licensed health care institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

      The proposed project is in response to the current high inpatient and observation case volumes and projections for future growth due to patients accessing the subspecialty care at VUMC. Patients from an extended service area, including out of state patients, utilize the facility.

      It appears that the application meets this criterion.

   b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

      This project is one component of the hospital's master planning process. Three other components of the master plan are detailed in the Certificate of Need for the Applicant-Outstanding Certificates of Need section of the Summary. These projects are in varying stages of completion. One of the projects, CN0710-075 AE, included shelled floor space at MCJCH to be built out at a later date. This project will relocate Maternal and Neonatal services from VUH to the shelled floor space at MCJCH. This relocation will free existing space at VUH, which

will be renovated to accommodate additional licensed and observation beds.

It appears that the application meets this criterion.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{\text{365 (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

   a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

   b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

Projected Need = Projected ADC + 2.33 x □Projected ADC

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

The Tennessee Department of Health's (TDH) report indicates there is a surplus of 2,608 acute care beds in the applicant's service area.

It appears that this criterion has not been met.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

According to the 2012 Joint Annual Reports, there were no hospitals in the applicant's service area that achieved 80% occupancy. The licensed bed occupancy for general acute care hospitals in the 41 county service area averaged 50.8% in 2011 and 50.3% in 2012. (Source: 2012 Joint Annual Report).

It appears that this criterion has not been met.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

All approved new acute care beds are not licensed. Please refer to the Certificate of Need information at the end of the staff summary for a more detailed explanation. Please also refer to the chart on the next page which displays the additional acute beds approved for VUMC and the distribution of the implementation of those beds since 2003.

Summit Medical Center (CN1402-004A) was approved at the May 28, 2014 meeting for the addition of 8 medical surgical beds which will increase the hospital's licensed bed complement from 188 to 196. However, the Division of Health Facilities, TDH, Licensed Facilities Report indicates the 8 approved surgical beds are not licensed. The remaining "Outstanding CON" projects listed at the back of the summary involve relocated or converted beds in the service area with no net bed changes other than Summit Medical Center, CN1402-004A.

BED APPROVAL AND DISTRIBUTION OF IMPLEMNTED BEDS AT VUMC

2003-PRESENT

CON #/Facility	*Licensed Beds*	Additional Beds Requested	Approved Beds at Completion	Outstanding Beds	Beds Implemented Between Projects/JARs
CN0309-075A Vanderbilt University Hospital	*719 September 2003*	32	805	54	54
CN0607-37A Vanderbilt University Hospital	*805 September 2006*	141	946	141	86
CN0710-075A Monroe Carell Jr. Children's Hospital	*836 January 2008 (includes 31 beds from CN0607-037A)*	105	1,051	215	31
2010 Joint Annual Report	*916*	N/A	N/A	135	80
2011 Joint Annual Report	*916*	N/A	N/A	135	0
2012 Joint Annual Report	*985*	N/A	N/A	66	69
2013 Provisional Joint Annual Report	*1,019*	N/A	N/A	32	34
CN1406-021 (pending)	*1,025 (current)*	108	1,159	26	6

Source: CN0309-075A, CN0607-037A, CN0710-075A, and JARs 2010-2013

The table above reflects the addition of acute care beds for Vanderbilt University Medical Center from 2003 to present. The chart above reflects the following:

- *Licensed beds have increased from 719 beds in 2003 to 1,025 in 2014, a 42.5% increase.*
- *VUMC has added a total of 278 acute care beds since 2003 with 108 beds pending in this application*
- *VUH has implemented annual bed additions to the hospital license since 2003 ranging from 6 beds in 2014 to 86 beds after its 2006 CON. 2011 is the only year during that timeframe that beds were not added to the license.*

Since there are currently outstanding and unimplemented acute care beds in the service area, it appears that this criterion has not been met.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

Special consideration is requested for the following reasons:

- *It is a tertiary care regional referral hospital, providing tertiary and quaternary care to patients in Tennessee and throughout the Southeast.*
- *High demand for adult and pediatric acute clinical care services due to their expertise and the specialties offered at VUMC.*
- *It has the only Level 1 Trauma Center, Level 4 Neonatal Intensive Care Unit, dedicated Burn Center, comprehensive transplant program, and NCI-designated Comprehensive Cancer Center in the State serving adults and children.*
- *More than 25% of VUMC patients are from outside the primary service area.*

It appears that this criterion has been met.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Vanderbilt University Medical Center owns and operates Vanderbilt University Hospital (VUH), Monroe Carell Jr. Children's Hospital (MCJCHV), and the Psychiatric Hospital at Vanderbilt (VPH) under one license. The proposed project will expand and renovate Vanderbilt University Hospital (VUH) and Monroe Carell Jr. Children's Hospital (MCJCHV) increasing the total licensed beds by 108 from 1,051 to 1,159. This application proposes to increase acute beds by 61, obstetrical beds by 23, and ICU/CCU/ (+PICU) care beds by 24.

An overview of the project is provided on page 4 of the original application.

The following chart reflects the changes in bed assignments after the completion of the project.

Bed Type	Current Bed Assignment	Proposed Bed Assignment	+/-
Med/Surg	443	504	61
Obstetrical	50	73	23
ICU/CCU/(+PICU)	241	265	24
Neonatal	100	100	n/a
Pediatric	129	129	n/a
Psychiatric	88	88	n/a
Total	**1,051**	**1,159**	**108**

Source: CN1406-021

The following are included in the proposed project:

MCJCHV

This project will build out three shelled in floors approved under CN0710-075AE which included the construction of a 372,140 square foot new building immediately adjacent and connected to the existing MCJCHV (621,420 square feet) building. This build out will accommodate the relocation of the obstetrical program, the newborn nursery and the neonatal unit currently located in VUH; the addition of 23 obstetrical beds; and the addition of 24 neonatal/pediatric critical care beds. Modifications by floor are listed below.

- 10th Floor-(1,000 GSF New Construction)-Two additional private inpatient beds will be added to the 36 previously approved beds to accommodate neonatal and pediatric intensive care, and acute care patients.

- 11th Floor-(42,000 GSF New Construction)-38 private inpatient beds will be added to accommodate neonatal and pediatric intensive care, and acute care patients. Two passenger elevators will be added.
- 12th Floor-(42,000 GSF New Construction)-38 Private inpatient beds will be added to accommodate postpartum patients and a newborn nursery.
- 13th Floor-(42,000 GSF New Construction)-14 Labor and delivery rooms, 21 private inpatient beds (Ante partum and Post-Partum), 3 Cesarean Section Operating Rooms, 4 Recovery Rooms.

VUH South Tower

- 7th Floor-(9,245 GSF Renovation) –The renovated unit will include 17 private observation beds. The seventh floor of the South Tower currently houses a neonatal unit. The neonatal unit will relocate to renovated space on the 4th floor of MCJCHV when vacated in June 2015.

VUH North Tower and East Tower

- 4th Floor- (49,814 GSF Renovation). 23 private inpatient intensive and acute care beds will be built. Cosmetic upgrades will be made to 38 acute care beds. Existing newborn nursery will be demolished and converted to 16 private observation beds.

The Vanderbilt Clinic (TVC)

- 1st Floor- (20,674 GSF Renovation) Renovation of a portion of the 1st floor includes 30 private observation patient rooms plus 6 psychiatric holding rooms.

Please refer to the Square Footage and Cost Per Square Footage Chart on page 8 of the original application for additional information.

Need

- 61 additional acute care beds are needed to increase inpatient capacity for future growth and back fill the area vacated by the obstetrical program.
- 24 pediatric neonatal/critical care beds will be needed that allows the flexibility to operate the unit as volumes fluctuate. MCJCHV has experienced a 3.8% annual growth rate over the past 7 years.
- The current obstetrical unit is running at 84% occupancy, target occupancy of 75% is needed to accommodate unplanned and unscheduled patients.

Note to Agency members: According to the DOH report, there is a surplus of 2,608 acute hospital beds in the service area.

Ownership
Vanderbilt University, by and through Vanderbilt University Medical Center, owns Vanderbilt University Hospital facilities. Vanderbilt has ownership interests in other health care facilities in Davidson, Maury, Montgomery, and Williamson Counties which are listed in Attachment A.4 in the original application. An organizational chart is included in Attachment A.4.

Facility Information

- VUH is a Level I Trauma Center as well as a Safety Net Hospital.
- The licensed bed complement of VUMC includes beds located in VUH, MCJCHV, and the Psychiatric Hospital at Vanderbilt (VPH).
- According to the TDH web-site, VUMC is currently licensed for 1,025 beds. The 2013 Provisional Joint Annual Report indicates VUH was licensed for 1,019 beds with 982 beds staffed. Licensed bed occupancy was 80.3% and staffed bed occupancy was 83.3%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- ***Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).***
- ***Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.***

Service Area Demographics
VUMC's declared primary service area includes the following counties:

Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Franklin, Giles, Grundy, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties.

- The total population of the 41 County Tennessee service area is estimated at 2,638,563 residents in calendar year (CY) 2014 increasing by approximately 5.5% to 2,786,319 residents in CY 2018.

- The overall Tennessee statewide population is projected to grow by 3.7% from 2014 to 2018.
- The latest 2014 percentage of the proposed primary service area population enrolled in the TennCare program is approximately 15.6% in the service area as compared to the statewide enrollment proportion of 17.3%.

Service Area Historical Utilization

Service Area Historical Utilization and Overall Market Share

Facility	Licensed Beds (2012)	2010 Patient Days	2011 Patient Days	2012 Patient Days	'10-'12 % Change	2010 Occup	2011 Occup.	2012 Occup.
41 County Service Area	7,639	1,424,030	1,427,101	1,402,089	-1.5%	51.7%	50.8%	50.3%
VUMC	985	271,747	283,009	283,062	+13.3%	81.3%	84.6%	78.7%
VUMC	11.4%	19.3%	19.8%	20.2%				

Source: CN1406-021 and JARs 2011-2013

The chart above reflects the following:

- Inpatient days in the 41 Tennessee County service area decreased 1.5% from 1,424,030 patient days in 2010 to 1,402,089 patient days in 2012.
- VUMC inpatient days increased 13.3% from 271,747 in 2010 to 283,062 in 2012.
- VUMC's licensed beds represented 11.4% of all licensed beds in the 41 County service area with market share of patient days increasing from 19.3% in 2010 to 20.2% in 2012.

Applicant's Historical and Projected Utilization

Historical and projected occupancy volumes for MCJCHV and VUH and the Obstetrics program are provided in the application. Historic and projected trends are displayed in the table below:

VUH	2011	2012	2013	Proposed Project Year 1 2020	Proposed Project Year 2 2021
Beds	542	576	610	Adult Care Inpatient 61	61
% Occupancy	82%	78%	78%	81%	83%
Obstetrics	Historical Volume			Obstetric	
Beds	48	50	50	23	23
% Occupancy	80.9%	77.4%	78.6%	81.2%	83.5%
MCJCHV	Historical Volume			Neonatal Pediatric Critical Care	
Beds	243	271	271	24	24
% Occupancy	83%	73%	83%	77%	79%

Source: CN1406-021

- Projected bed occupancy of the proposed addition of 61 adult acute care beds will average 82% in the Years 2020 and 2021.
- Occupancy of the 23 additional obstetric beds in 2020 and 2021 will average 81.2% and 83.5%, respectively.
- Occupancy of the 24 additional neonatal/pediatric critical care beds in 2020 and 2021 will average 77% and 79%, respectively.

Project Cost

Major costs are:

- Construction Costs plus contingencies- $86,501,195 or 73.1% of total cost.
- Fixed and moveable equipment- $23,530,755, or 19.9% of the total cost.
- Average total construction cost is expected to be $373.55 per square foot. The third quartile for cost per square foot of previously approved hospital projects from 2011-2013 was $324.00. The applicant states that the reasons for the higher cost include higher constructions costs involved with facilities, mechanical requirements and construction over existing patient care areas.
- For other details on Project Cost, see the Project Cost Chart on page 28 of the original application.

Historical Data Chart

- According to the Historical Data Chart VUMC experienced profitable net operating results for two of the three most recent years reported: $102,795,178 for 2011; $104,181,348 for 2012; and ($23,201,131) for 2013.
- Average Annual Net Operating Income (NOI) was unfavorable at approximately -1.3% of annual net operating revenue for the year 2013.

Projected Data Chart

- 6,508 inpatient discharges are projected in Year 2020 and 7,957 inpatient discharges in Year 2021 specific to this proposed project.
- Net operating income less capital expenditures for the proposed project will equal $35,819,093 in Year 2020 increasing to $42,042,719 in Year 2021.

Charges

In Year One of the proposed project, the average charge per case is as follows:

Average Gross Charge
- $80,941

Average Deduction from Operating Revenue
- $55,501

Average Net Charge
- $25,440

Medicare/TennCare Payor Mix

- TennCare/Medicaid-Charges for VUMC will equal $105,933,190 in Year One representing 20% of total gross revenue.
- Medicare- Charges will equal $141,433,114 in Year One representing 27% of total gross revenue.

Financing

The proposed project will be financed through a combination of cash reserves totaling $47,476,950 and tax-exempt debt of $70.8 million dollars issued through a conduit issuer.

A June 12, 2014, letter from Cecelia Moore, Vanderbilt University Medical Center's Associate Vice Chancellor of Finance, confirms the applicant has sufficient cash reserves to finance the proposed project. A letter dated July 1, 2014 from J.P. Morgan in the supplemental response states the following, "based upon the University's stand-alone credit ratings, J.P. Morgan would expect the university to be able to access the public debt markets". For planning purposes, VUMC is assuming a fixed rate issuance for 15 years at 7.25% interest.

Vanderbilt Universities' audited financial statements for the period ending June 30, 2013 indicates $845,472,000 in cash and cash equivalents, total current assets of $1,420,186,000 total current liabilities of $829,369,000 and a current ratio of 1.71:1.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant's proposed changes in direct patient staffing due to the proposed project are presented in the table below:

Position	Proposed
Registered Nurse	243
Medical Receptionist	38
Care Partner	62
Total	**343**

Licensure/Accreditation

VUMC is licensed by the Tennessee Department of Health.

VUMC is accredited by The Joint Commission with an accreditation cycle effective July 28, 2012 valid for up to thirty-six (36) months. A report from The Joint Commission dated September 24, 2012 is included in Attachment C., Contribution to the Orderly Development of Healthcare.7.d.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **three** years.

Note to Agency Members: If approved, VUMC requests an extended expiration date of six years, which is three years beyond the normal expiration date for hospital projects. The Project Completion Chart on page 40 of the original application indicates the initiation of service for the proposed project is projected to occur in April 2019.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no Letters of Intent, pending or denied applications for this applicant.

Outstanding Certificates of Need

Vanderbilt University Hospitals, CN1309-034A, has an outstanding certificate of Need that will expire on February 1, 2017. The Certificate of Need was approved at the December 18, 2013 Agency meeting for the expansion and renovation to the existing third floor operating suite by 4 operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville (Davidson County), TN. **The estimated project cost is $4,695,707.** *Project Status: According to a September 4, 2014 email from a Vanderbilt representative, the area for expansion and renovation to accommodate 4 operating rooms and shell space for 2 future operating rooms is currently under construction. The timeline for construction completion is October 2014, and a target opening of November 2014 pending completion of licensure survey.*

Vanderbilt University Hospital, CN0606-037A, has an outstanding Certificate of Need that will expire on July 1, 2015. The Certificate of Need was approved at the September 27, 2006 Agency meeting to renovate 77,120 square feet of existing space and to construct 307,470 square feet of new space, the centerpiece of which is a ten story bed tower, which will be placed between the existing VUH building and The Vanderbilt Clinic (TVC). The proposed project includes the addition of one hundred forty-one (141) acute care beds including the conversion of an existing skilled nursing unit to acute care beds, the relocation and expansion of cardiac catheterization services, the relocation of a clinical research unit, and the net increase of twelve operating suites. The estimated project cost is **$234,421,471.** *Project Status: According to an annual progress reported dated July 1, 2014, the fifth floor, including the relocated cardiac catheterization and EP labs, was completed in January 2014. All beds are completely licensed, and in operation.*

Monroe Carell Jr. Children's Hospital at Vanderbilt, CN0710-075AE, has an outstanding Certificate of Need that will expire on March 1, 2018. The Certificate of Need was approved at the January 23, 2008 Agency meeting to expand the existing Monroe Carell Jr. Children's Hospital (MCJCHV) through an adjacent building connected to the existing hospital. The expansion will provide 90 additional pediatric acute critical care beds, 26 neonatal intensive care beds (16 relocated), and an expanded obstetrical service including 36 relocated postpartum beds, 12 new antepartum beds, 16 labor and delivery suites (12 relocated), 2 relocated operating rooms and 1 new obstetric operating room. Five pediatric operating rooms are proposed on the third floor which will also contain 5 additional shelled operating rooms to accommodate continued growth. MCJCHV is not licensed separately from Vanderbilt University Hospital (VUH). VUH's licensed bed capacity will increase from 946 to 1,051. The estimated project cost is **$248,326,286.00**. *Project Status: According to a September 4, 2014 email from a Vanderbilt representative, architectural and engineering drawings have been*

initiated since the January 22, 2014 Agency meeting. During the January 22, 2014 meeting the following was approved: request for modification in the floor plan which resulted in a decrease in square footage from 372,140 SF to 210,000 SF and decreasing the project cost from $248,326,286 to $120,000,000. The project was granted a 4 year extension to March 1, 2018.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent or denied applications for other health care organizations proposing this type of service.

Pending Applications

Skyline Medical Center, CN1406-020, has a pending application scheduled to be heard at the Agency's September 24, 2014 meeting. The proposed project is to increase the licensed bed capacity at the hospital's campus by 10 beds. The beds will be utilized as medical-surgical and intensive care beds. The beds will be added by renovating existing space at the main campus which is located at 3441 Dickerson Pike, Nashville (Davidson County), TN. Simultaneously, 10 licensed beds will be closed at the Skyline satellite campus at 500 Hospital Drive, Madison (Davidson County), TN. TriStar Skyline Medical Center is currently licensed as an acute care hospital with 385 hospital beds. This project will increase beds at the main campus from 213 to 223 beds, and will reduce the satellite campus from 172 to 162 beds, so that the consolidated 385-bed licensed will not change. The estimated project cost is **$3,951,732.00**.

Tristar Centennial Medical Center, CN1407-032, has a pending application scheduled to be heard at the Agency's October 22, 2014 meeting for the construction and renovation to the hospital that includes: 1) the development of a Joint Replacement Center of Excellence that will include 10 additional operating rooms; 2) updates to the emergency department that will improve workflow; and 3) the addition of 29 medical/surgical beds which will increase the total licensed beds from 657 to 686. The estimated project cost is **$92,192,007**.

Outstanding Certificates of Need:

Saint Thomas Hospital-Midtown, CN1401-001A, has an outstanding certificate of need that will expire on June 1, 2017. The application was approved at the April 23, 2014 Agency meeting for the development of a Joint Replacement Service by consolidating orthopedic operating rooms currently located on two different floors of STM and by relocating operating rooms (OR) at Saint Thomas

West Hospital to STM. The service will contain ten (10) surgical joint replacement suites, PACU and Prep/Recovery private bay areas, and two (2) dedicated nursing units with a total of 62 private patient rooms. There will be no net increase to the OR complement of Saint Thomas Health – Nashville if the OR complement in Saint Thomas Hospital, CN110-037A is voluntarily reduced by 4 ORs. This project will not change the hospital's 683 licensed bed complement. The total estimated project cost is **$25,832,609.** *Project status update: This project was recently approved.*

Summit Medical Center, CN1402-004A, has outstanding certificate of need that will expire July 1, 2017. The application was approved at the May 28, 2014 Agency meeting for the addition of 8 medical surgical beds which will increase the hospital's licensed bed complement from 188 to 196. The new beds will be located in renovated space on the 7th floor. The estimated project cost is **$1,812,402.** *Project Status Update: This project was recently approved.*

Hendersonville Medical Center, CN1302-002A, has an outstanding Certificate of Need which will expire on August 1, 2016. It was approved at the June 26, 2013 Agency meeting to construct a new fourth floor of medical surgical beds and initiate Level IIB Neonatal Intensive Care services in a new six (6) licensed Level IIB Neonatal Intensive Care Unit (NICU) on its campus at 355 New Shackle Island Road, Hendersonville (Sumner County) Tennessee, 37075. The proposed project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are located at its main Hendersonville campus and 38 are located at its satellite campus at 105 Redbud Drive, Portland (Sumner County), TN 37148. The applicant will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The estimated cost of the project is **$32,255,000.00.** *Project Status: Per an e-mail dated May 12, 2014, the Chief Operations Officer of the medical center advised that the hospital is in process of finishing design drawings over the next 90 -120 days. Once approved, construction is expected to begin in early 2015.*

Williamson County Hospital District d/b/a Williamson Medical Center, CN1210-048A, has an outstanding Certificate of Need which will expire on March 1, 2017. It was approved at the January 23, 2013 Agency meeting for the construction and renovation project that will renovate and expand surgery and surgery support areas on the east side of the main hospital building and construct a three-story addition on the west side of the main hospital building for pediatric services and shelled space for future relocation of obstetrics services. The estimated project cost is **$67,556,801.00.** *Project Status: A 9/9/2014 email from a*

representative of Williamson Medical Center indicated site work is complete and the project is currently on schedule and within budget.

Saint Thomas Medical Center, CN1110-037A, has an outstanding certificate of need that will expire on March 1, 2017. The application was approved at the January 25, 2012 Agency meeting for the 3-phase hospital renewal project for various services and area: renovation of 89,134 SF of hospital space; construction an adjoined 6-level 135,537 SF patient tower; and the addition of a GE Discovery CT scanner. The estimated project cost is **$110,780,000.** *Project Status update: Review of the 4/2/14 annual progress report revealed that Phase 1 of the project (renovations to the second floor ICU rooms) is 100% complete, with review by TDH occurring in March 2014. The OR renovations and Emergency Department CT are currently in construction ahead of schedule and are at 5% and 15% completion, respectively. Phase 2 work (new tower construction) is scheduled to begin mid/late-2014 and some Phase 3 work (reconfiguration of space that is not dependent on relocation of services to the new tower) is planned to start in the next several months. The overall project is expected to be complete in early 2017.*

United Regional Medical Center, CN0707-060A, has an outstanding certificate of need that will expire on December 18, 2014. The application was approved at the December 12, 2007 Agency meeting for the relocation and replacement of the existing hospital from 1001 McArthur Drive to McArthur Drive and Oak Drive, Manchester. New construction will consist of 98,240 SF. There will be no change in the 54 licensed beds and no existing services will be discontinued. The total estimated project cost is **$37,845,000.** *Project status update: United Regional Medical Center is investigating other alternatives to the outstanding CON.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
(9/9/2014)

LETTER OF INTENT

State of Tennessee 20
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before June 9 (Month / day), 2014 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Vanderbilt University Hospitals (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Vanderbilt University with an ownership type of not-for-profit

and to be managed by: Vanderbilt University Hospitals intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion and renovation of various existing facilities on its campus at 1211 Medical Center Drive, Nashville, Tennessee, including the build out of three previously approved floors at Monroe Carell Jr. Children's Hospital at Vanderbilt ("MCJCHV") to accommodate (1) the relocation of the obstetrical program, the newborn nursery and the neonatal unit currently located in Vanderbilt University Hospital ("VUH") to MCJCHV; (2) the addition of 23 obstetrical beds; and (3) the addition of 24 neonatal/ pediatric critical care beds. The space vacated in VUH due to relocations to MCJCHV will be renovated to accommodate the addition of 61 adult acute care inpatient beds. Other areas in VUH will be renovated to accommodate a total of 63 observation beds. The project will require approximately 79,783 square feet of renovation, 126,686 square feet of new construction, and will increase the total licensed bed number by 108. The project does not involve the initiation of new health care services or acquisition of major medical equipment The estimated project cost is $118,276,950.

The anticipated date of filing the application is: June 12, 2014

The contact person for this project is Ginna Felts (Contact Name) Business Development (Title)

who may be reached at: Vanderbilt University Medical Center (Company Name) 3319 West End Avenue, Suite 920 (Address)

Nashville (City) TN (State) 37203 (Zip Code) 615/936-6005 (Area Code / Phone Number)

Ginna Felts (Signature) 6.9.14 (Date) Ginna.rader@vanderbilt.edu (E-mail Address)

State of Tennessee 21
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY
-Application
Vanderbilt University Hospital

CN1406-021

1. ***Name of Facility, Agency, or Institution***

Vanderbilt University Hospitals
Name

1211 Medical Center Drive — Davidson
Street or Route — County

Nashville — TN — 37232
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Ginna Felts — Consultant, Business Development
Name — Title

Vanderbilt University Medical Center — ginna.rader@vanderbilt.edu
Company Name — Email address

3319 West End Ave. Suite 920 — Nashville — TN — 37203
Street or Route — City — State — Zip Code

Employee — 615-936-6005 — 615-936-5310
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution: Attachment A.3***

Vanderbilt University Hospitals — 615-322-3454
Name — Phone Number

1211 Medical Center Drive — Davidson
Street or Route — County

Nashville — TN — 37232
City — State — Zip Code

4. ***Type of Ownership of Control (Check One): Attachment A.4***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation(For Profit)		I. Other (Specify)_____	
E. Corporation (Not-for-Profit)	X		

5. ***Name of Management/Operating Entity (If Applicable) Not Applicable***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

6. ***Legal Interest in the Site of the Institution (Check One): Attachment A.6***

A.	Ownership	X	D.	Option to Lease	_____
B.	Option to Purchase	_____	E.	Other (Specify) _____	_____
C.	Lease of _____ Years	_____			

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) acute	X	I.	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	J.	Outpatient Diagnostic Center	_____
			K.	Recuperation Center	_____
C.	ASTC, Single Specialty	_____	L.	Rehabilitation Facility	_____
D.	Home Health Agency	_____	M.	Residential Hospice	_____
E.	Hospice	_____	N.	Non-Residential Methadone Facility	_____
F.	Mental Health Hospital	_____	O.	Birthing Center	_____
G.	Mental Health Residential Treatment Facility	_____	P.	Other Outpatient Facility (Specify)_____	_____
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)	_____	Q.	Other (Specify) _____	_____

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution	_____	G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	X
B.	Replacement/Existing Facility	_____			
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Ambulatory Surgery	_____			
E.	Treatment Center Discontinuance of OB Services	_____	H.	Change of Location	_____
			I.	Other (Specify)_____	_____
F.	Acquisition of Equipment	_____			

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

RESPONSE: Please see the completed bed chart below.

		Current Beds Licensed	CON Approved Bed Projects (Unimplemented)	Staffed Beds	Beds Proposed (in this CON)	Total Beds at Completion (of all Projects)
A.	Medical	231	(10)	210	-	221
B.	Surgical	222	-	222	61	283
C.	Long-Term Care	-	-	-	-	-
D.	Obstetrical	50	-	50	23	73
E.	ICU/CCU (+PICU)	205	36	205	24	265
F.	Neonatal	100	-	100	-	100
G.	Pediatric	129	-	129	-	129
H.	Adult Psychiatric	88	-	88	-	88
I.	Geriatric Psychiatric	-	-	-	-	-
J.	Child/Adolescent	-	-	-	-	-
K.	Rehabilitation	-	-	-	-	-
L.	Nursing Facility (non-	-	-	-	-	-
M.	Nursing Facility Level	-	-	-	-	-
N.	Nursing Facility Level	-	-	-	-	-
O.	Nursing Facility Level	-	-	-	-	-
P.	ICF/MR	-	-	-	-	-
Q.	Adult Chemical	-	-	-	-	-
R.	Child and Adolescent	-	-	-	-	-
S.	Swing Beds	-	-	-	-	-
T.	Mental Health	-	-	-	-	-
U.	Residential Hospice	-	-	-	-	-
	TOTAL	**1,025**	**26**	**1,004**	**108**	**1,159**

10 Medicare Provider Number 440039: Acute Care

Certification Type Inpatient facility

11. Medicaid Provider Number 440039: Acute Care

Certification Type Inpatient facility

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

RESPONSE: Not Applicable

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? YES If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

RESPONSE: See Attachment A.13 for existing MCO contracts.

SECTION B: PROJECT DESCRIPTION

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Vanderbilt University, by and through its Vanderbilt University Medical Center, owns the Vanderbilt University Hospital (VUH) and the Monroe Carell Jr. Children's Hospital at Vanderbilt (MCJCHV). These facilities operate under one hospital license as Vanderbilt University Hospitals, and they are collectively known as Vanderbilt University Medical Center (VUMC).

As a result of a master planning process, the proposed project will expand and renovate the existing facilities by increasing the total bed number by 108 to 1,159. The following major components will be included in this project:

- **Build out of three shelled bed floors recently approved in the MCJCHV expansion (CN0710-075).**
  - **Two floors will include the obstetrical program relocated from VUH as well as an additional 23 obstetrical beds (+21 antepartum/ postpartum and +2 labor and delivery rooms (LDRs)). In addition, two C-section rooms will be relocated and one C-section room will be added. The normal newborn nursery will also be relocated from VUH.**
  - **One floor will include the addition of 22 neonatal/ pediatric critical care beds and the relocation of the Stahlman 16-bed neonatal unit from the 4th floor of VUH.**
  - **The remaining 2 neonatal/ pediatric critical care beds requested will be added to the 36 beds (CN0710-075) on the first floor of the MCJCHV vertical expansion.**
- **Renovation of the vacated (obstetrical) space in VUH will be backfilled with 61 adult acute care inpatient beds.**
- **Addition of three observation units on the VUMC campus will house 63 observation beds.**

The increase in inpatient and observation beds is necessary due to the consistently high occupancy at both campuses and projections for future growth as patients continue to access the subspecialty care available at VUMC. As a major referral hospital serving Tennessee and the Southeast, high utilization continues to tax the capacity of the existing hospitals.

No major medical equipment will be involved.

The expected project cost is $118,276,950. Funding will be provided through a combination of capital resources, including tax-exempt debt and cash reserves. Vanderbilt expects to finance the project with generated and/or borrowed funds to ensure that adequate funds will be available for the project at a reasonable cost. At the discretion of Vanderbilt, financing for part of the cost of the project may be obtained from publicly issued securities.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: As a continuation of the Clinical Master Plan, the next phase is to increase the capacity of VUH and MCJCHV by completing the MCJCHV vertical expansion. The vertical expansion at MCJCHV will house 4-floors. (The construction costs of the vertical expansion were included in the previously approved CN0710-075. This project included three shelled floors as well as one complete 36-bed pediatric unit.)

This project reflects the model that VUMC has used with recent project planning. Specifically, inpatient units are built to allow for flexibility of use. A floor by floor complete description of the current project is provided below.

MCJCHV Vertical Expansion

TENTH FLOOR

	SCHEDULE
EST. START OF CONSTRUCTION =	July 2015
EST. LENGTH OF CONSTRUCTION =	28 Months
EST. COMPLETION OF CONSTRUCTION =	October 2017

TENTH FLOOR = 1,000 GSF NEW CONSTRUCTION & 0 GSF RENOVATION

This application seeks approval of two additional private inpatient beds to be added to the 36 previously approved inpatient bed build-out of the floor. These rooms will be built to accommodate neonatal intensive care, pediatric intensive care, and acute care patients.

ELEVENTH FLOOR

	SCHEDULE
EST. START OF CONSTRUCTION =	July 2017
EST. LENGTH OF CONSTRUCTION =	10 Months
EST. COMPLETION OF CONSTRUCTION =	May 2018

ELEVENTH FLOOR = 42,000 GSF NEW CONSTRUCTION & 0 GSF RENOVATION

This application seeks approval to build out the eleventh floor to include 38 private inpatient rooms plus necessary core, nursing and administrative support. The inpatient rooms will be built to accommodate neonatal intensive care, pediatric intensive care, and acute care patients. Additional patient care areas include 1 treatment room. As part of this fit-out, two new passenger elevators will be added to the existing core, and connected through to the lower levels.

TWELFTH FLOOR

	SCHEDULE
EST. START OF CONSTRUCTION =	July 2017
EST. LENGTH OF CONSTRUCTION =	10 Months
EST. COMPLETION OF CONSTRUCTION =	May 2018

TWELFTH FLOOR = 42,000 GSF NEW CONSTRUCTION & 0 GSF RENOVATION

This application seeks approval to build out the twelfth floor to include 38 private inpatient rooms plus necessary core, nursing and administrative support. The inpatient rooms will be designed to accommodate postpartum patients with in-room nursing. Additional patient care areas include a newborn nursery.

THIRTEENTH FLOOR

	SCHEDULE
EST. START OF CONSTRUCTION =	July 2017
EST. LENGTH OF CONSTRUCTION =	10 Months
EST. COMPLETION OF CONSTRUCTION =	May 2018

THIRTEENTH FLOOR = 42,000 GSF NEW CONSTRUCTION & 0 GSF RENOVATION

This application seeks approval to build out of the thirteenth floor to include 14 Labor and Delivery (LDR) rooms, and 21 private inpatient rooms, designed to accommodate Ante Partum and Post-Partum patients. Additional patient care areas include 3 Cesarean Section Operating Rooms, 4 recovery rooms, plus necessary core, nursing and administrative support

VUH

SEVEN SOUTH

	SCHEDULE
EST. START OF CONSTRUCTION =	June 2015
EST. LENGTH OF CONSTRUCTION =	6 Months
EST. COMPLETION OF CONSTRUCTION =	December 2015

SEVENTH FLOOR = 0 GSF NEW CONSTRUCTION & 9,245 GSF RENOVATION

The seventh floor of the VUH South Tower is currently a neonatal unit. This will be vacated in June 2015, when the NICU relocates to renovated space on the fourth floor of MCJCHV. Once vacated, the seventh floor will be renovated as necessary to provide the unit with a cosmetic upgrade. Anticipated renovation includes new flooring throughout, replacement of sheetrock ceilings with acoustic tile, headwall upgrades, new doors and hardware, and alterations to the staff lounge to increase equipment storage space. The renovated unit will be used for observation patients. The unit will accommodate 17 patients in private rooms, 15 of which have private toilets. Two toilet rooms with showers will be included in the core along with other necessary core, and nursing program.

FOUR NORTH & FOUR EAST (MCE)

	SCHEDULE
EST. START OF CONSTRUCTION =	April 2018
EST. LENGTH OF CONSTRUCTION =	10 Months
EST. COMPLETION OF CONSTRUCTION =	February 2019

FOURTH FLOOR = 0 GSF NEW CONSTRUCTION & 49,814 GSF RENOVATION

The fourth floor of the VUH North Tower and East Tower will be vacated by Obstetrics at the completion of the MCJCHV Twelfth and Thirteenth Floor Renovation projects previously referenced. Once vacated, the areas will be renovated to accommodate inpatient and observation patients.

The renovation of Four North will include the demolition of existing inpatient rooms, which will be rebuilt as 23 private inpatient rooms with toilets. These rooms will be built to accommodate intensive care and acute care patients. Core and ancillary space on the floor will be updated as necessary to support the unit. In addition satellite nursing stations will be provided.

The renovation of Four East will include cosmetic upgrades to 38 existing inpatient rooms with toilets. These rooms are sized for acute care patients. An existing normal newborn nursery will be demolished and converted to an observation unit with 16 private patient rooms with toilets. Core and support space on the floor will be updated as necessary to support the inpatient and observation units.

The Vanderbilt Clinic (TVC)

FIRST FLOOR

	SCHEDULE
EST. START OF CONSTRUCTION =	**January 2015**
EST. LENGTH OF CONSTRUCTION =	**8 Months**
EST. COMPLETION OF CONSTRUCTION =	**September 2015**

FIRST FLOOR = 0 GSF NEW CONSTRUCTION & 20,674 GSF RENOVATION

A portion of the first floor of TVC will be converted to an Observation Unit. The renovated space currently is occupied by Oral Surgery, GI/Endoscopy Services, VPEC (Pre-Admission Testing), and Psychiatric Holding/ Emergency Services. These services will be permanently relocated prior to renovation, with the exception of Psychiatric Holding/ Emergency Services, which will occupy space in the completed renovation. Construction will be phased to accommodate Psychiatric Holding. The completed renovation will include 30 private observation patient rooms with toilets plus six psychiatric holding rooms.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: The chart below portrays the changes in bed assignments after the completion of this project.

	Current Beds Assignment *	Proposed Bed Assignment	+/-
Medical/ Surgical	443	504	61
Obstetrical	50	73	23
ICU/CCU (+PICU)	241	265	24
Neonatal	100	100	-
Pediatric	129	129	-
Psychiatry	88	88	-
TOTAL	**1,051**	**1,159**	**108**

***includes remaining approved but unimplemented bed projects**

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF	
					Renovated	New	Total	Cost/SF	Total
23 Adult Inpatient Beds	None	0	None	VUH 4N	14,993	0	14,993		$6,369,479
38 Adult Inpatient Beds	None	0	None	VUH 4E	11,492	0	11,492		$5,042,730
16 Adult Observation Beds	None	0	None	VUH 4E	10,131	0	10,131		$5,374,530
30 Adult Observation Beds	None	0	None	TVC 1	14,300	0	14,300		$10,337,000
17 Adult Observation Beds	None	0	None	VUH 7S	6,612	0	6,612		$2,311,250
40 NICU/Critical Care Pediatric Beds & Elevator Addition	None/ VUH 4	7,996	None	MCJCHV 11 MCJCHV 10	0	30,265	30,265		$19,113,942
59 Obstetric Beds, 14 LDRs, 3 C-Section Rooms & Normal Nursery	None/ VUH 4/ MCE 4	45,530	None	MCJCHV 12 MCJCHV 13	0	58,960	58,960		$28,577144
B. Unit/Depart. GSF Sub-Total					57,528	89,211	146,739		Included above
C. Mechanical/ Electrical GSF					1,539	2,499	4,038		Included above
D. Circulation/ Structure GSF					20,716	34,976	55,692		Included above
E. Total GSF					**79,783**	**126,686**	**206,469**	**$373.55**	**$77,126,075**

30

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: All services requested in this application are existing services at VUMC. The need for expansion of acute care beds is addressed in the section of the application specific to the service. The need for each of the respective services is a consequence of substantial volume increases experienced over the last several years and this volume increase is anticipated to continue.

D. Describe the need to change location or replace an existing facility.

RESPONSE: This project does not include change in location or replacement of an existing facility.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment: **RESPONSE: Not Applicable**

    a. Describe the new equipment, including:

        1. Total cost; (As defined by Agency Rule).
        2. Expected useful life;
        3. List of clinical applications to be provided; and

    b. Documentation of FDA approval.

    c. Provide current and proposed schedules of operations

2. For mobile major medical equipment: **RESPONSE: Not Applicable**

    a. List all sites that will be served;

b. Provide current and/or proposed schedule of operations;

c. Provide the lease or contract cost;

d. Provide the fair market value of the equipment; and

e. List the owner for the equipment.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not Applicable

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include:**

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction;
4. Names of streets, roads or highway that cross or border the site.

RESPONSE: The proposed site consists of 4.1 acres; please see Attachment B.Project Description.III.A

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: VUMC is accessible from most major transportation routes including Highways I-65, I-440, and I-40. Public transportation access includes bus stops near the hospital on 21st Avenue South.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

RESPONSE: Please see Attachment B.Project Description.IV – Floor Plan

V. For a Home Health Agency or Hospice, identify: **RESPONSE: Not Applicable**

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care.

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

    a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project.

    b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

    RESPONSE: Specific responses to the Tennessee's Health: Guidelines for Growth for Acute Care Beds is provided below.

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how the CON application supports the principle.

RESPONSE: Vanderbilt's plans are also similar to the Five Principals for Achieving Better Heath as articulated in the State Health Plan.

A. **Healthy Lives: The proposed project will improve the health of the service area through the improved efficiencies gained by expanding the inpatient units at VUH and MCJCHV, thus allowing more individuals to seek the subspecialty care available at VUMC.**

B. **Access to Care: The proposed project will improve access to care by allowing VUMC to expand capacity of the subspecialty care available. Recent Blue Cross Blue Shield of Tennessee white paper evidences the in-migration to major referral centers from the outlying areas. In Vanderbilt's case, much of this in-migration is no doubt a product of the complete array of subspecialties available both at VUH and MCJCHV.**

C. **Economic Efficiencies: The proposed project will achieve operational efficiencies by expanding the capacity at VUH and MCJCHV and by relocating the maternal program closer to MCJCHV. Vanderbilt is committed to an evidenced-based approach to the delivery of care, which will also assure cost-effective approaches to patient care.**

D. **Quality of Care: The proposed project will achieve the highest standards of quality through quality metrics and best practices. Vanderbilt is actively engaged in many projects associated with quality and safety outcomes and is recognized as a national leader in this regard.**

E. **Health Care Workforce: Vanderbilt is committed to providing world-class care at the medical center, and thus, recruiting and retaining the best employee workforce. This will be an increasing challenge in the healthcare environment in the future as resources and reimbursement become more constrained.**

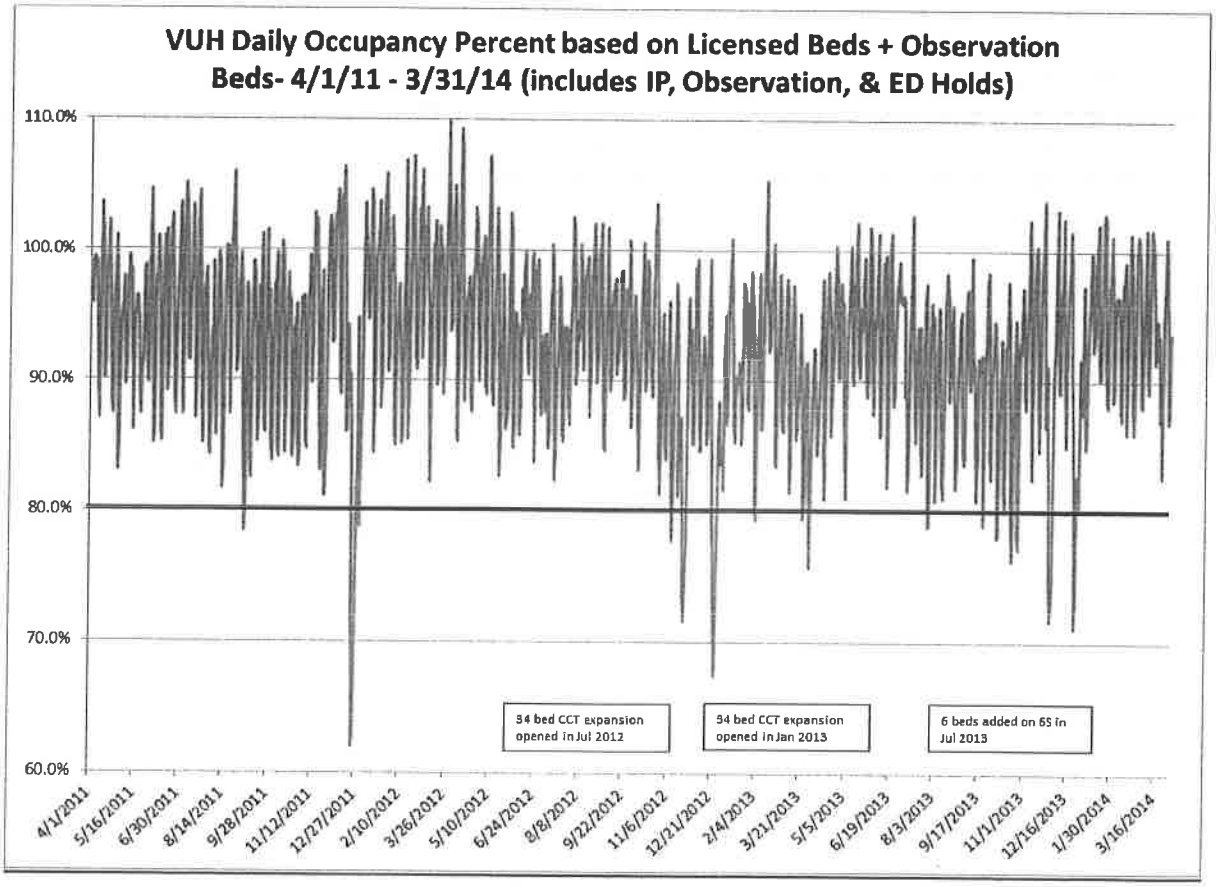
Acute Care Beds:

RESPONSE: Vanderbilt continues to experience high demand for adult and pediatric clinical patient care services due to the expertise and specialties available only at VUMC. VUMC has the only Level 1 Trauma Center, Level 4 Neonatal Intensive Care Unit, dedicated Burn Center, comprehensive transplant program, and NCI-designated Comprehensive Cancer Center in the state servicing adults and children. In addition, VUMC is consistently named one of the Top 100 National Hospitals by Thomson Reuters and scores an "A" by The Leapfrog Group's national review for safety, quality and affordability. Vanderbilt's commitment to research also continues to drive patients to the medical center, as it ranks in the top 10 in overall NIH funding.

As stated in the project description, this project involves multiple layers of addition and relocation of acute care beds across the medical center based on the different needs of both VUH and MCJCHV.

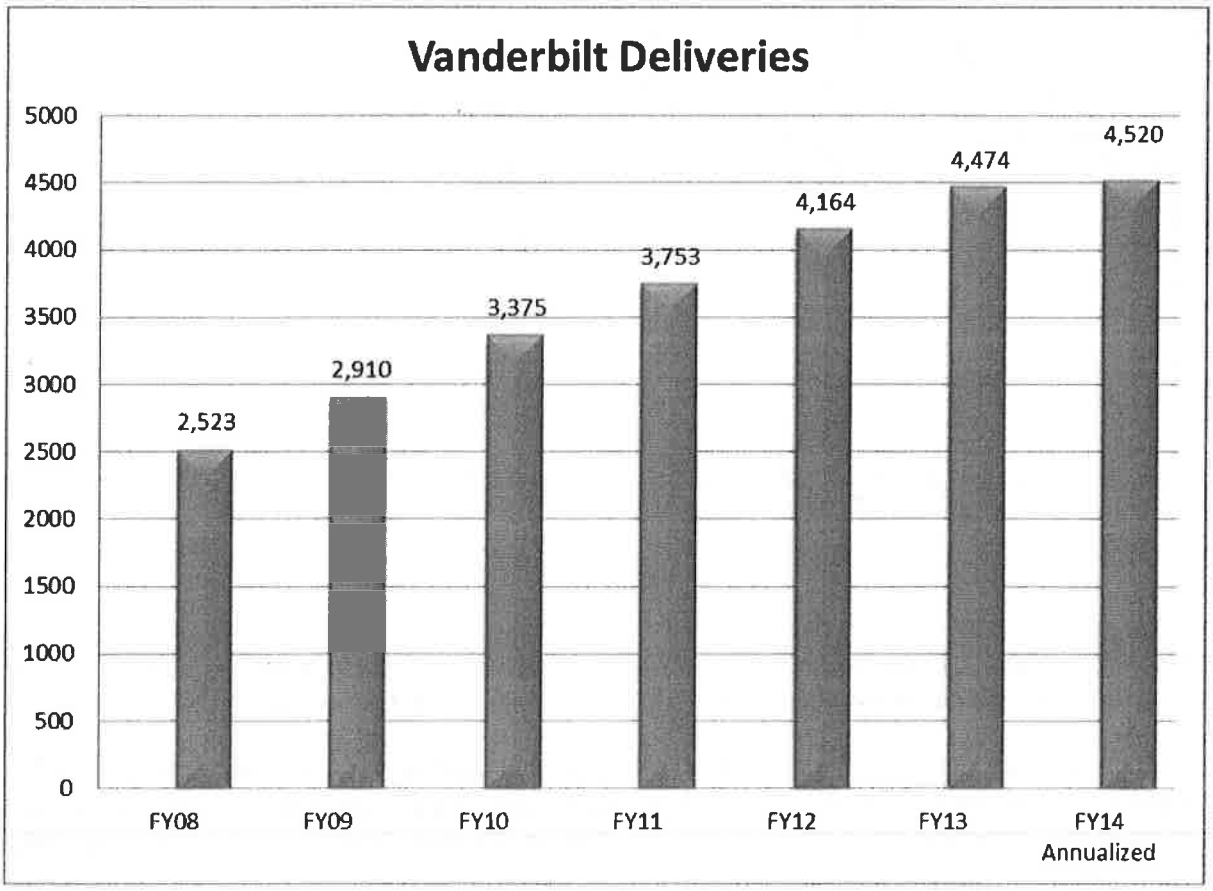
<u>Vanderbilt University Hospital</u>:

In 2013, VUH had eleven adult patient care specialties ranked in the U.S. *News & World Report's* annual rankings. As a result of quality of services and expertise of faculty, occupancy at VUH has consistently been above 90%. Even with the construction and opening of the Critical Care Tower over the last several years, patients quickly filled those beds and VUH resumed higher than normal levels of occupancy. In fact, the Critical Care Tower expansion demonstrated the need for additional intensive care beds. However, the patients in the Critical Care Tower are staying longer in the intensive care unit than anticipated due to a shortage of acute care beds for their extended recovery. In addition, the over use of the emergency department has increased the demand for the beds at VUH, especially since patients arriving in the emergency department are sicker often due to delayed medical care. This demand for services at VUH has continued to occur while other area medical centers operate at much lower occupancy levels. As seen in the chart below, VUH's daily occupancy consistently operate above 90% over the last several years.



Obstetrical:

In addition, the obstetrical program at VUMC has experienced tremendous growth over the last five years. Deliveries at VUH have increased by 80% from 2,500 delivers to over 4,500 in 2014, resulting in tremendous pressure on the current obstetrical unit. This demand has been escalated by the high quality maternal fetal medicine program at VUH and the multiple obstetrical specialty clinics including The Fetal Center at Vanderbilt, the Comprehensive Care Clinic (HIV/AIDS medical clinic), the Diabetes Clinic, the Congenital Heart Disease Clinic for Pregnant Women, and the Bariatric Obstetric Care Clinic. These specialty clinics draw patients from Middle Tennessee and beyond to seek medical specialists available at VUH. Through the coordinated care provided at VUH, the mothers' prenatal team consults with the specialists at MCJCHV who will be caring for the babies after delivery. This coordination of care allows for a seamless process and allows for improved outcomes for the mothers and babies.

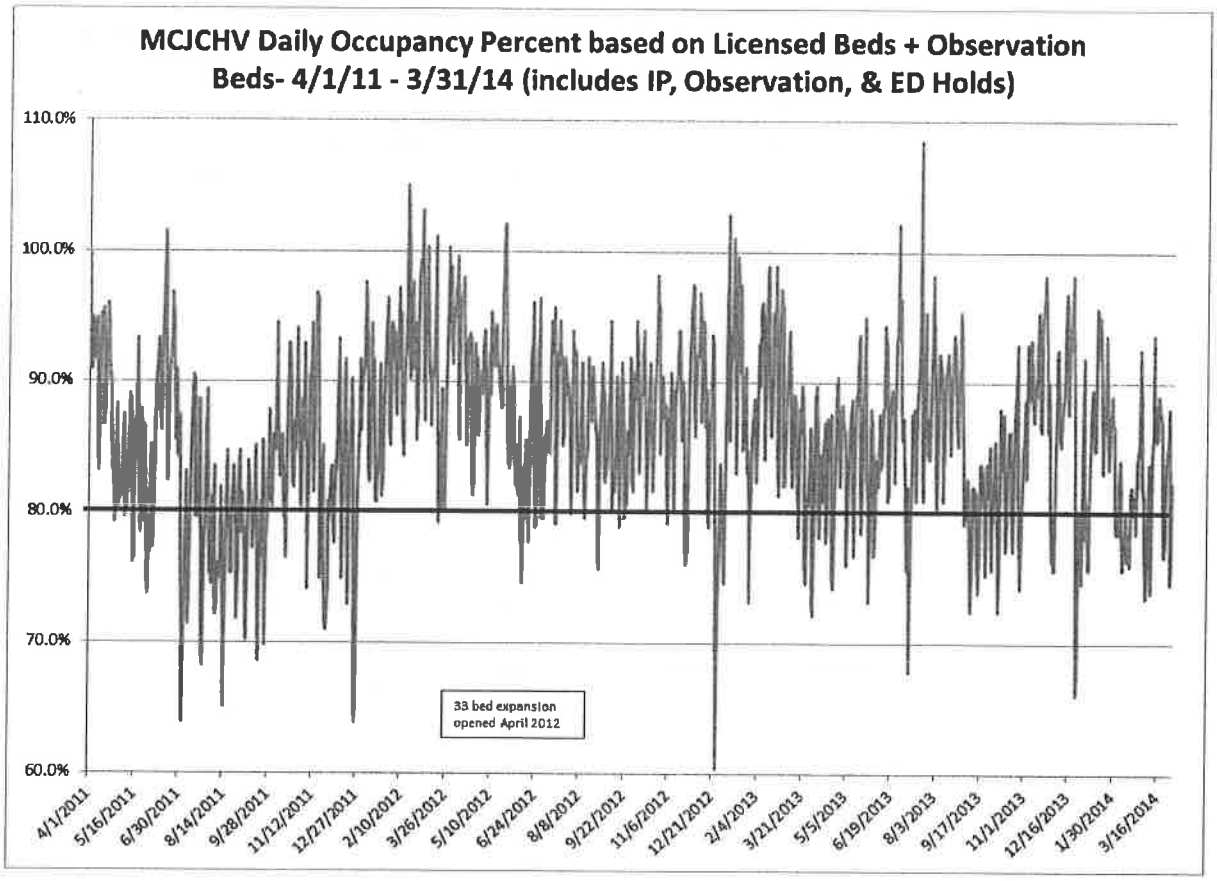


Monroe Carell Jr. Children's Hospital at Vanderbilt:

MCJCHV is the region's only comprehensive pediatric health care provider. MCJCHV continues to receive national recognition for its exceptional patient care. In 2013, MCJCHV was named among the top pediatric health care providers in the *U.S. News & World Report's* annual Best Children's Hospitals rankings; nine of its pediatric specialty programs were recognized. In addition, MCJCHV has received national recognition from *Parents* magazine and Children's Hospital Association.

Due to the quality of services and expertise of faculty, discharges and patient days at MCJCHV have consistently been above 90% occupancy. Even with the construction and May 2012 opening of the 33-bed expansion, patients quickly filled those beds, and MCJCHV resumed higher than normal levels of occupancy due to patients from all

over the country seeking the expertise associated with these nationally ranked programs. As seen in the chart below, MCJCHV's daily occupancy consistently operates higher than the State's recommended 80% occupancy threshold.



1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year (guidelines detail the steps of the bed need projection methodology).

   RESPONSE: Please see the following chart portraying the total bed need for Tennessee by county for the next 5 years. As indicated in the chart, there is a surplus of licensed beds in every county in Tennessee. The source is the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Bedford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	60	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	25	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	25	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	351	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	60	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	115	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	121	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	36	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	214	159	-101	-46
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-315
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	40	27	-23	-10
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	71	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	157	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	225	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	46	10	-40	-4
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	152	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	209	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	95	81	-58	-44
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	240	170	-141	-71
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	51	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	58	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	62	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	45	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	142	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	15	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	25	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	25	25	-15	-15

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Jackson														
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	58	58	-21	-21
Johnson	51	0	1	233	232	232	0	1	0	1	2	2	-1	-1
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Lake														
Lauderdale	3,044	8	15	4,293	4,252	4,218	8	15	8	15	25	25	-10	-10
Lawrence	9,298	26	37	18,503	18,540	18,545	26	37	26	37	99	80	-62	-43
Lewis														
Lincoln	7,435	20	31	17,852	18,159	18,898	21	31	22	32	59	59	-27	-27
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
McNairy	4,953	14	22	11,089	11,200	11,451	14	22	14	23	45	45	-22	-22
Macon	3,793	10	18	5,934	6,057	6,301	11	18	11	19	25	25	-6	-6
Madison	179,979	493	616	281,828	283,339	286,657	496	620	502	627	787	729	-160	-102
Marion	14,492	40	54	9,647	9,762	9,980	40	55	41	56	70	63	-14	-7
Marshall	675	2	5	1,895	1,911	1,956	2	5	2	5	25	12	-20	-7
Maury	42,096	115	144	102,509	102,974	104,036	116	145	117	146	255	215	-109	-69
Meigs														
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Montgomery	43,692	120	150	126,007	130,796	139,341	124	155	132	165	270	220	-105	-55
Moore														
Morgan														
Obion	10,628	29	42	20,715	20,637	20,560	29	42	29	41	173	85	-132	-44
Overton	16,555	45	61	21,794	22,030	22,558	46	62	47	63	114	82	-51	-19
Perry	6,000	16	26	5,114	5,146	5,192	17	26	17	26	53	25	-27	1
Pickett														
Polk	0	0	0											
Putnam	61,949	170	212	105,866	108,424	113,926	174	217	183	228	247	243	-19	-15
Rhea	3,533	10	17	7,701	7,893	8,211	10	17	10	18	25	25	-7	-7
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Robertson	16,379	45	61	28,555	29,416	31,016	46	62	49	65	109	66	-44	-1
Rutherford	80,182	220	275	229,262	241,520	267,897	231	289	257	321	387	369	-66	-48
Scott														
Sequatchie														
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Shelby	934,049	2,559	3,199	1,416,974	1,430,639	1,457,026	2,584	3,230	2,631	3,289	4,177	3,115	-888	174
Smith	10,604	29	42	13,707	13,945	14,448	30	42	31	44	98	85	-54	-41
Stewart														
Sullivan	242,753	665	831	417,761	423,735	435,560	675	843	693	867	1,056	769	-189	98
Sumner	48,799	134	167	115,476	119,215	126,486	138	173	146	183	303	213	-120	-30
Tipton	4,341	12	20	12,974	13,252	13,875	12	20	13	21	100	44	-79	-23
Trousdale	1,678	5	10	2,060	2,117	2,220	5	10	5	10	25	21	-15	-11
Unicoi	4,283	12	20	6,172	6,198	6,244	12	20	12	20	48	7	-28	13

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

    a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds rather than on staffed beds.

RESPONSE: Please see the following chart portraying the Tennessee hospital occupancy levels for the most recent Joint Annual Report (2012) based on licensed beds. (The chart includes acute care hospitals only; rehabilitation and behavioral health hospitals were omitted.) Most hospitals are not maintaining occupancy levels greater than 80%. The source is the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

2012 Joint Annual Report of Hospitals
Excludes rehabilitation and behavioral health facilities

Facility	County	Licensed Beds	Staffed Beds	Admissions	Days	Occupancy of Licensed Beds
Methodist Medical Center of Oak Ridge	Anderson	301	255	11,575	49,355	45%
Heritage Medical Center	Bedford	60	60	2,271	7,326	33%
Camden General Hospital	Benton	25	12	360	1,971	22%
Erlanger-Bledsoe	Bledsoe	25	25	214	2,751	30%
Blount Memorial Hospital	Blount	304	238	12,385	53,384	48%
Skyridge Medical Center	Bradley	251	177	9,499	36,171	39%
Skyridge Medical Center Westside	Bradley	100	30	968	4,594	13%
Jellico Community Hospital, Inc.	Campbell	54	31	1,688	5,033	26%
Tennova Healthcare - Lafollette Medical Center	Campbell	66	66	2,265	11,295	47%
Stones River Hospital	Cannon	60	50	821	6,667	30%
Baptist Memorial Hospital - Huntingdon	Carroll	70	33	657	2,946	12%
McKenzie Regional Hospital	Carroll	45	35	1,763	4,392	27%
Sycamore Shoals Hospital	Carter	121	79	4,108	16,105	36%
Centennial Medical Center at Ashland City	Cheatham	12	12	194	1,551	**35%**
Claiborne County Hospital	Claiborne	85	39	1,590	7,523	24%
Cumberland River Hospital	Clay	36	34	789	4,939	**38%**
Tennova Healthcare - Newport Medical Center	Cocke	74	36	2,628	7,602	28%
Harton Regional Medical Center	Coffee	135	107	5,543	22,186	45%
Medical Center of Manchester	Coffee	25	16	1,706	5,814	64%
United Regional Medical Center	Coffee	54	36	1,011	3,551	18%
Cumberland Medical Center	Cumberland	189	123	6,114	23,205	34%
Baptist Hospital	Davidson	683	453	29,792	125,686	50%
Centennial Medical Center	Davidson	657	630	25,830	147,903	62%
Metro Nashville General Hospital	Davidson	150	116	4,675	18,919	35%
Saint Thomas Hospital	Davidson	541	404	22,621	100,202	51%
Skyline Medical Center	Davidson	213	209	9,773	52,021	67%
Skyline Medical Center Campus	Davidson	182	110	3,646	26,727	40%
Southern Hills Medical Center	Davidson	132	81	4,077	17,845	37%
Summit Medical Center	Davidson	188	137	10,779	42,722	62%
The Center for Spinal Surgery	Davidson	23	23	1,144	1,519	18%
Vanderbilt University Hospitals	Davidson	985	966	53,818	283,062	79%
Decatur County General Hospital	Decatur	40	27	843	3,410	23%
DeKalb Community Hospital	DeKalb	71	56	1,136	4,107	16%
Horizon Medical Center	Dickson	157	120	4,391	18,099	32%
Dyersburg Regional Medical Center	Dyer	225	120	4,925	13,367	16%
Methodist Healthcare - Fayette	Fayette	46	10	214	704	4%
Jamestown Regional Medical Center	Fentress	85	54	1,987	6,186	20%
Emerald - Hodgson Hospital	Franklin	21	21	519	1,898	25%
Southern Tennessee Medical Center	Franklin	131	89	4,435	21,031	44%

Facility	County	Licensed Beds	Staffed Beds	Admissions	Days	Occupancy of Licensed Beds
Gibson General Hospital	Gibson	77	32	336	1,224	4%
Humboldt General Hospital	Gibson	62	30	492	2,058	9%
Milan General Hospital	Gibson	70	28	319	1,766	7%
Hillside Hospital	Giles	95	81	1,734	7,680	22%
Laughlin Memorial Hospital	Greene	140	140	4,105	16,643	33%
Takoma Regional Hospital	Greene	100	30	2,657	11,424	31%
Lakeway Regional Hospital	Hamblen	135	65	3,506	14,689	30%
Morristown - Hamblen Healthcare System	Hamblen	167	147	7,428	26,972	44%
Erlanger East	Hamilton	41	37	4,909	10,382	69%
Erlanger Medical Center	Hamilton	690	491	27,238	133,260	53%
Erlanger North	Hamilton	12	12	268	3,746	86%
Memorial Healthcare System, Inc.	Hamilton	336	336	21,395	99,485	81%
Memorial North Park	Hamilton	69	69	4,194	16,982	67%
Parkridge East Hospital	Hamilton	128	113	5,393	19,103	41%
Parkridge Medical Center, Inc.	Hamilton	275	177	8,270	40,134	40%
Wellmont Hancock County Hospital	Hancock	10	10	261	1,199	33%
Bolivar General Hospital	Hardeman	51	23	309	821	4%
Hardin Medical Center	Hardin	58	49	1,645	5,679	27%
Wellmont Hawkins County Memorial Hospital	Hawkins	50	46	1,291	3,530	19%
Haywood Park Community Hospital	Haywood	62	36	593	1,592	7%
Henderson County Community Hospital	Henderson	45	45	818	2,449	15%
Henry County Medical Center	Henry	142	101	4,063	17,227	33%
Hickman Community Hospital	Hickman	15	15	-	-	0%
Patients' Choice Medical Center of Erin	Houston	25	25	643	2,872	31%
Three Rivers Hospital	Humphreys	25	25	487	1,699	19%
Tennova Healthcare - Jefferson Memorial Hospital	Jefferson	58	58	2,300	9,456	45%
Johnson County Community Hospital	Johnson	2	2	26	53	7%
East Tennessee Children's Hospital	Knox	152	152	5,901	40,530	73%
Fort Sanders Regional Medical Center	Knox	517	378	18,368	90,737	48%
Mercy Medical Center West	Knox	101	101	4,808	17,612	48%
North Knoxville Medical Center	Knox	108	72	3,281	14,922	38%
Parkwest Medical Center	Knox	307	297	17,690	77,911	70%
Tennova Healthcare	Knox	111	243	15,563	74,903	185%
University of Tennessee Memorial Hospital	Knox	581	534	26,236	140,304	66%
Lauderdale Community Hospital	Lauderdale	25	25	535	3,050	33%
Crockett Hospital	Lawrence	99	80	2,587	9,211	25%
Lincoln Medical Center	Lincoln	59	59	1,995	7,803	36%
Fort Loudoun Medical Center	Loudon	50	30	1,724	6,195	34%
Macon County General Hospital	Macon	25	25	946	3,775	41%
Jackson - Madison County General Hospital	Madison	635	601	30,392	156,148	67%
Regional Hospital of Jackson	Madison	152	128	7,565	28,378	51%

Facility	County	Licensed Beds	Staffed Beds	Admissions	Days	Occupancy of Licensed Beds
Grandview Medical Center	Marion	70	63	1,900	10,802	42%
Marshall Medical Center	Marshall	25	12	207	675	7%
Maury Regional Hospital	Maury	255	215	13,641	45,838	49%
Athens Regional Medical Center	McMinn	118	63	2,747	9,407	22%
McNairy Regional Hospital	McNairy	45	45	1,646	5,165	31%
Sweetwater Hospital Association	Monroe	59	59	2,459	10,587	49%
Gateway Medical Center	Montgomery	270	220	13,234	45,331	46%
Baptist Memorial Hospital - Union City	Obion	173	85	3,039	10,551	17%
Livingston Regional Hospital	Overton	114	82	3,385	16,524	40%
Perry Community Hospital	Perry	53	25	904	6,000	31%
Copper Basin Medical Center	Polk	25	25	902	4,308	47%
Cookeville Regional Medical Center	Putnam	247	243	14,346	64,089	71%
Rhea Medical Center	Rhea	25	25	1,014	3,535	39%
Roane Medical Center	Roane	105	36	1,694	6,620	17%
NorthCrest Medical Center	Robertson	109	66	4,513	17,053	43%
Middle Tennessee Medical Center	Rutherford	286	268	18,607	70,595	68%
StoneCrest Medical Center	Rutherford	101	101	4,934	15,472	42%
LeConte Medical Center	Sevier	79	69	4,924	14,324	50%
Baptist Memorial Hospital	Shelby	706	573	25,440	170,707	66%
Baptist Memorial Hospital - Collierville	Shelby	81	81	2,451	9,655	33%
Baptist Memorial Hospital for Women	Shelby	140	140	11,572	37,666	74%
Delta Medical Center	Shelby	243	177	3,965	33,171	37%
Lebonheur Children's Medical Center	Shelby	255	228	9,488	57,743	62%
Methodist Healthcare - Memphis Hospitals	Shelby	617	416	18,230	120,042	53%
Methodist Hospital - Germantown	Shelby	309	309	19,678	81,132	72%
Methodist Hospital - North	Shelby	246	207	10,971	62,286	69%
Methodist Hospital - South	Shelby	156	144	7,676	31,682	56%
Saint Francis Hospital	Shelby	519	326	15,830	90,401	48%
Saint Francis Hospital - Bartlett	Shelby	196	156	7,139	35,317	49%
Saint Jude Children's Research Hospital	Shelby	78	64	2,988	15,667	55%
The Regional Medical Center at Memphis	Shelby	631	294	15,779	96,178	42%
Riverview Regional Medical Center North	Smith	63	50	805	3,652	16%
Riverview Regional Medical Center South	Smith	35	35	1,470	7,129	56%
Indian Path Medical Center	Sullivan	239	169	7,030	26,312	30%
Wellmont - Holston Valley Medical Center, Inc.	Sullivan	505	339	19,232	88,387	48%
Wellmont Bristol Regional Medical Center	Sullivan	312	261	15,304	65,052	57%
Hendersonville Medical Center	Sumner	110	96	5,551	20,434	51%
Portland Medical Center	Sumner	38	-	-	-	0%
Sumner Regional Medical Center	Sumner	155	117	7,422	29,432	52%
Baptist Memorial Hospital - Tipton	Tipton	100	44	1,881	5,012	14%
Trousdale Medical Center	Trousdale	25	21	390	1,680	18%

b) All outstanding new acute care bed CON projects in the proposed service area are licensed.

RESPONSE: Please see the list of unimplemented acute care bed CON projects in the primary service area listed below. The Vanderbilt University Hospital CN0606-037 is nearing completion with all bed floors licensed.

Monroe Carell Jr. Children's Hospital at Vanderbilt	**CN0710-075**
Vanderbilt University Hospital	**CN0606-037**
Summit Medical Center	**CN1402-004**

c) The Health Facility Commission may give special consideration to acute care bed proposal for specialty health service units in tertiary care regional referral hospitals.

RESPONSE: Special consideration is requested for the additional acute care beds proposed in this application due to the fact that VUMC is a tertiary care regional referral hospital, providing tertiary care and quaternary care to patients in Tennessee and throughout the Southeast. VUMC continues to experience consistently high occupancy levels as demonstrated in the charts above. VUMC has the only Level 1 Trauma Center, Level 4 Neonatal Intensive Care Unit, dedicated Burn Center, comprehensive transplant program, and NCI-designated Comprehensive Cancer Center in the state servicing adults and children. More than 25% of VUMC's patients derive from outside the primary service area, resulting in patients from outlying regions seeking VUH and MCJCHV for specialty care.

NEED (CONTINUED)

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE: As VUMC continues to implement its long-range master plan, this project allows for the next phase to be achieved. As a major referral hospital, high utilization continues to place pressure on VUMC's capacity. This phase also allows for the obstetrical and pediatric services to be consolidated into one facility. The obstetrical area vacated will alleviate the overcrowding currently being experience at VUH by adding 61 adult acute care beds. As stated earlier in the application, VUMC's occupancy trends remain well-above the 80% threshold. These additional inpatient beds coupled with observation units will allow the appropriate care to be delivered in the appropriate place for the patients across the medical center. The vertical expansion (approved in CN0710-075) was decided on due to paucity of remaining space on campus. The master plan expects to accommodate medical center patient care needs for the foreseeable future.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: The area to be served by this proposal is represented in the attached Service Area map (Attachment C.Need.3). The primary service area includes the counties of Davidson, the counties surrounding Davidson, and Central TN; the secondary service area includes East and West Tennessee as well as specific counties in Western Kentucky. The primary service area is reasonable since 74% of the VUMC's

patients derive from this area; an additional 19% come from the secondary service area. The remaining come from 47 other states across the country.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Please see Attachment C.Need.4.A.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: Forty-five percent of Vanderbilt University Medical Center's patients were TennCare/ Medicaid, Medicare, and uninsured inpatients, which is evidence of the commitment to low-income and elderly consumers. VUMC provides services to all consumers irrespective of gender, race, ethnicity or income.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: The following tables show the most recent three years of data for acute care bed utilization in the primary service area. The source is the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Hospitals with unimplemented acute care bed CONs have been highlighted in grey.

Facility	County	2012							2011							2010						
		Licensed Beds	Staffed Beds	Admissions	Days	Average Length of Stay	Average Daily Census	Occupancy of Licensed Beds	Licensed Beds	Staffed Beds	Admissions	Days	Average Length of Stay	Average Daily Census	Occupancy of Licensed Beds	Licensed Beds	Staffed Beds	Admissions	Days	Average Length of Stay	Average Daily Census	Occupancy of Licensed Beds
Heritage Medical Center	Bedford	60	60	2,271	7,326	3.2	20	33%	60	60	2,602	8,738	3.4	24	40%	60	60	3,234	10,418	3.2	29	48%
Stones River Hospital	Cannon	60	50	821	6,667	8.1	18	30%	60	50	957	7,410	7.7	20	34%	60	50	1,090	8,263	7.6	23	38%
Centennial Medical Center at Ashland City	Cheatham	12	12	194	1,551	8.0	4	35%	12	12	182	1,567	8.6	4	36%	12	12	182	1,462	8.0	4	33%
Cumberland River Hospital	Clay	36	34	789	4,939	6.3	14	38%	36	34	845	4,729	5.6	13	36%	36	34	845	4,699	5.6	13	36%
Harton Regional Medical Center	Coffee	135	107	5,543	22,186	4.0	61	45%	135	107	5,977	23,773	4.0	65	48%	137	109	6,252	23,519	3.8	64	47%
Medical Center of Manchester	Coffee	25	16	1,706	5,814	3.4	16	64%	25	11	1,271	4,925	3.9	13	54%	25	17	1,229	4,102	3.3	11	45%
United Regional Medical Center	Coffee	54	36	1,011	3,551	3.5	10	18%	54	36	1,330	4,418	3.3	12	22%	54	54	1,591	4,605	2.9	13	23%
Cumberland Medical Center	Cumberland	189	123	6,114	23,205	3.8	64	34%	189	133	6,703	26,906	4.0	74	39%	182	145	7,289	29,218	4.0	80	44%
Baptist Hospital	Davidson	683	453	29,792	125,686	4.2	344	50%	683	453	30,405	127,732	4.2	350	51%	683	453	30,296	129,703	4.3	355	52%
Centennial Medical Center	Davidson	657	630	25,830	147,903	5.7	405	62%	606	584	23,187	139,114	6.0	381	63%	606	584	26,104	151,222	5.8	414	68%
Metro Nashville General Hospital	Davidson	150	116	4,675	18,919	4.0	52	35%	150	114	5,142	22,460	4.4	62	41%	150	114	5,575	24,605	4.4	67	45%
Saint Thomas Hospital	Davidson	541	404	22,621	100,202	4.4	275	51%	541	396	22,623	102,534	4.5	281	52%	541	397	22,806	102,851	4.5	282	52%
Skyline Medical Center	Davidson	213	209	9,773	52,021	5.3	143	67%	213	195	9,152	51,710	5.7	142	67%	213	185	8,950	48,437	5.4	133	62%
Skyline Medical Center Campus	Davidson	182	110	3,646	26,727	7.3	73	40%	233	110	3,617	27,321	7.6	75	32%	245	110	3,106	22,348	7.2	61	25%
Southern Hills Medical Center	Davidson	132	81	4,077	17,845	4.4	49	37%	132	101	3,548	15,693	4.4	43	33%	120	92	3,580	15,042	4.2	41	34%
Summit Medical Center	**Davidson**	**188**	**137**	**10,779**	**42,722**	**4.0**	**117**	**62%**	**188**	**113**	**9,984**	**39,877**	**4.0**	**109**	**58%**	**188**	**121**	**10,396**	**41,759**	**4.0**	**114**	**61%**
The Center for Spinal Surgery	Davidson	23	23	1,144	1,519	1.3	4	18%	23	23	1,127	1,505	1.3	4	18%	23	23	1,273	1,702	1.3	5	20%
Vanderbilt University Hospitals	**Davidson**	**985**	**966**	**53,818**	**283,062**	**5.3**	**776**	**79%**	**916**	**909**	**52,453**	**283,009**	**5.4**	**775**	**85%**	**916**	**906**	**51,874**	**271,747**	**5.2**	**745**	**81%**
DeKalb Community Hospital	DeKalb	71	56	1,136	4,107	3.6	11	16%	71	56	1,211	4,636	3.8	13	18%	71	56	1,303	4,792	3.7	13	18%
Horizon Medical Center	Dickson	157	120	4,391	18,099	4.1	50	32%	157	122	4,546	20,164	4.4	55	35%	157	122	4,840	20,314	4.2	56	35%
Jamestown Regional Medical Center	Fentress	85	54	1,987	6,186	3.1	17	20%	85	54	2,239	7,904	3.5	22	25%	85	54	2,269	7,609	3.4	21	25%
Emerald - Hodgson Hospital	Franklin	21	21	519	1,898	3.7	5	25%	21	21	545	2,052	3.8	6	27%	21	21	600	2,318	3.9	6	30%
Southern Tennessee Medical Center	Franklin	131	89	4,435	21,031	4.7	58	44%	131	89	4,486	21,236	4.7	58	44%	131	89	4,820	22,119	4.6	61	46%
Riverside Hospital	Giles	95	81	1,734	7,680	4.4	21	22%	95	81	1,596	7,160	4.5	20	21%	95	81	1,875	9,208	-	25	27%
Hickman Community Hospital	Hickman	15	15	-	-	-	-	0%	25	25	370	1,170	-	3	13%	15	15	422	1,128	2.7	3	21%
Patients' Choice Medical center of Erin	Houston	25	25	643	2,872	4.5	8	31%	35	35	826	4,045	4.9	11	32%	25	25	842	3,880	4.6	11	43%
Three Rivers Hospital	Humphreys	25	25	487	1,699	3.5	5	19%	25	25	489	1,756	3.6	5	19%	25	25	447	1,573	3.5	4	17%
Crockett Hospital	Lawrence	99	80	2,587	9,211	3.6	25	25%	99	80	2,866	10,448	3.6	29	29%	99	80	3,053	11,563	3.8	32	32%
Lincoln Medical Center	Lincoln	59	59	1,995	7,803	3.9	21	36%	59	59	1,879	8,058	4.3	22	37%	59	59	1,787	8,665	4.8	24	40%
Macon County General Hospital	Macon	25	25	946	3,775	4.0	10	41%	25	25	823	3,352	4.1	9	37%	25	25	760	3,272	4.3	9	36%
Marshall Medical Center	Marshall	25	12	207	675	3.3	2	7%	25	12	280	883	3.2	2	10%	25	12	386	1,226	3.2	3	13%
Maury Regional Hospital	Maury	255	215	13,641	45,838	3.4	126	49%	255	206	15,233	56,141	3.7	154	60%	255	206	15,256	52,304	3.4	143	56%
Gateway Medical Center	Montgomery	270	220	13,234	45,331	3.4	124	46%	270	220	13,067	47,191	3.6	129	48%	270	247	13,742	47,802	3.5	131	49%
Livingston Regional Hospital	Overton	114	82	3,385	16,524	4.9	45	40%	114	82	3,623	17,775	4.9	49	43%	114	82	3,872	17,798	4.6	49	43%
Perry Community Hospital	Perry	53	25	904	6,000	6.6	16	31%	53	39	1,067	6,677	6.3	18	35%	53	-	1,160	7,108	6.1	19	37%
Cookeville Regional Medical Center	Putnam	247	243	14,346	64,089	4.5	176	71%	247	242	14,075	62,403	4.4	171	69%	247	224	13,839	60,370	4.4	165	67%
NorthCrest Medical Center	Robertson	109	66	4,513	17,053	3.8	47	43%	109	66	4,780	18,773	3.9	51	47%	109	66	5,247	20,097	3.8	55	51%
Middle Tennessee Medical Center	Rutherford	286	268	18,607	70,595	3.8	193	68%	286	286	18,634	73,964	4.0	203	71%	286	225	16,530	66,135	4.0	181	63%
StoneCrest Medical Center	Rutherford	101	101	4,934	15,472	3.1	42	42%	101	101	4,604	14,082	3.1	39	38%	101	101	5,404	15,927	2.9	44	43%
Riverview Regional Medical Center North	Smith	63	50	805	3,652	4.5	10	16%	63	48	1,476	6,197	4.2	17	27%	63	54	1,456	6,146	4.2	17	27%
Riverview Regional Medical Center South	Smith	35	35	1,470	7,129	4.8	20	56%	25	10	157	1,920	12.2	5	21%	25	15	156	1,712	11.0	5	19%
Hendersonville Medical Center	Sumner	110	96	5,551	20,434	3.7	56	51%	148	81	4,748	18,732	3.9	51	35%	110	82	4,608	17,618	3.8	48	44%
Portland Medical Center	Sumner	38	0	-	-	-	-	0%	38	0	-	-	-	-	0%	38	22	-	-	-	-	0%
Sumner Regional Medical Center	Sumner	155	117	7,422	29,432	4.0	81	52%	155	155	7,196	27,713	3.9	76	49%	155	96	7,445	28,408	3.8	78	50%
Trousdale Medical Center	Trousdale	25	21	390	1,680	4.3	5	18%	25	21	497	2,260	4.5	6	25%	21	21	614	2,839	4.6	8	37%
River Park Hospital	Warren	125	48	3,263	11,625	3.6	32	25%	125	50	3,347	13,695	4.1	38	30%	125	50	3,528	14,921	4.2	41	33%
Wayne Medical Center	Wayne	80	32	591	1,991	3.4	5	7%	80	32	628	2,106	3.4	6	7%	80	32	664	2,374	3.6	7	8%
White County Community Hospital	White	60	44	1,438	7,189	5.0	20	33%	60	44	1,390	6,547	4.7	18	30%	60	44	1,233	3,520	2.9	10	16%
Williamson Medical Center	Williamson	185	185	9,618	35,700	3.7	98	53%	185	185	9,965	37,657	3.8	103	56%	185	185	9,846	36,465	3.7	100	54%
University Medical Center	Wilson	170	170	6,156	25,474	4.1	70	41%	170	170	6,420	26,983	4.2	74	43%	170	170	6,658	29,117	4.4	80	47%

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE:

	FY11	FY12	FY13	FY20 (Y1)	FY21 (Y2)
VUH					
Beds	542	576	610	61	61
Discharges	31,623	32,159	34,467	5,751	6,982
Days	162,153	163,502	173,987	29,370	35,040
Average Daily Census	444	448	477	80	96
Average Length of Stay	5.1	5.1	5.0	5.1	5.0
Total VUH Occupancy (including Incremental)	82%	78%	78%	81%	83%
Obstetrics					
Beds	48	50	50	23	23
Discharges	4,190	4,589	4,998	493	711
Days	12,151	13,323	15,324	1,741	2,394
Average Daily Census	33	37	42	5	7
Average Length of Stay	2.9	2.9	3.1	3.5	3.4
Total Obstetrics Occupancy (including Incremental)	69%	73%	84%	64%	66%
MCJCHV					
Beds	243	271	271	24	24
Discharges	9,946	9,989	10,945	264	264
Days	74,012	72,166	81,875	7,008	7,008
Average Daily Census	203	198	224	19	19
Length of Stay	7.4	7.2	7.5	26.5	26.5
Total MCJCHV Occupancy (including Incremental)	83%	73%	83%	77%	79%

The calculations used to support the request for additional beds are as follows:

- **VUH: As demonstrated earlier, VUH clearly needs more inpatient capacity. The decision to add 61 acute care beds is a consequence of relocating the obstetrical program to the MCJCHV vertical expansion. Given that the obstetrical unit is currently serving in an inpatient capacity, the back-fill with acute care beds is an operationally sound approach. Calculations utilized for this unit included an analysis of the overall occupancy rate of VUH given the addition of the 61 acute care beds. In the chart above, note that occupancy levels remain high after project completion.**

- **Observation: Although observation beds are not specifically addressed in bed need formulas, these beds have become essential in the day-to-day operations of a healthcare facility. Using FY13 observation patient days, one calculation suggests the need for 90 observation beds at VUH. Currently, VUH has only 13 dedicated observation beds. However, on a daily basis, inpatient beds are often used for observation patients. This use of inpatient beds is not ideal.**

- **MCJCHV: A proprietary study completed for MCJCHV by a globally respected healthcare consulting company indicated that the additional neonatal/ critical care capacity is demanded due to the following reasons:**
    - **Increased demand from high utilization demographic groups,**
    - **Increased utilization due to an improving economy and an increase in higher risk births due to higher occurrences of maternal diabetes and obesity,**
    - **Increase in ALOS due to an increase in fertility treatments that lead to multiples and premature births, more women inducing early and enhanced technologies to keep younger babies alive.**

  The demand forecast in the proprietary study is reasonably conservative in that projection levels are below the level of growth experienced at MCJCHV. For example, the propriety study used a 2.9% neonatal growth rate per year while MCJCHV has experienced a 3.8% annual growth rate over the last seven years. The 24 pediatric neonatal/ critical care beds proposed in this application will be built to intensive care standards and will offer MCJCHV the flexibility to run the unit as volumes indicate. For example, the current 4th floor of MCJCHV contains neonatal "pods," which during peak seasons can flexed to accommodate the changing needs of the hospital.

- **Obstetrical: The obstetric demand is twofold. First, the obstetrical unit at VUH is currently running at 84% occupancy. This is considered to be less than ideal for high-quality care. To ensure a 95% confidence level regarding beds needed when patients arrive unplanned/ unscheduled, it is vital that the unit has target occupancy of 75%. In addition, with the move to MCJCHV, triage will occur in the inpatient beds, as opposed to in a separate triage unit, resulting in the need for additional obstetrical beds. Furthermore, due to the relocation to MCJCHV vertical expansion, overflow of obstetrical patients to non-maternal units is not likely due to distance from other adult units.**

  Second, the continued growth in the maternal fetal medicine program and the complex subspecialty prenatal care provided, coupled with the minimal 1% growth rate forecasted support the obstetrical volumes projected in the chart. As one of three hospitals in the country that performs fetal surgery, it is anticipated that additional high-risk antepartum beds will be needed. As the proprietary study highlighted, there are more highly-complex patients with advanced maternal age and co-morbidities (including diabetes, obesity, substance abuse, HIV/AIDS), which contribute to longer lengths of stay, higher complications and repeated hospitalization.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

    - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

      RESPONSE: See Attachment C. Economic Feasibility.1

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$3,780,000
	2.	Legal, Administrative, Consultant Fees	$20,000
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	$77,126,075
	6.	Contingency Fund	$9,375,120
	7.	Fixed Equipment	$3,972,792
	8.	Moveable Equipment (List all equipment over $50,000) Anesthesia Machine (3) Blood Gas Analyzer (1) Central Station Monitor (6) GE Ultrasound (1) Medication Dispenser (3) Monitoring System (1) Phillips X-ray (1)	$19,557,963
	9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:		
	1.	Facility	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)_____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	$4,400,000
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$118,231,950
E.	CON Filing Fee		$45,000
F.	Total Estimated Project Cost(D+E)		
		TOTAL	**$118,276,950**

SUPPLEMENTAL

REVISED PAGE 29 OF APPLICATION

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

X B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

X E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

__ F. Other—Identify and document funding from all other sources.

RESPONSE: Vanderbilt expects to finance the project with generated and/or borrowed funds to ensure that adequate funds will be available for the project at a reasonable cost. At the discretion of Vanderbilt, financing for part of the cost of the project may be obtained from publicly issued securities. Please see Attachment C, Economic Feasibility.2.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: The chart provided below shows the average hospital construction cost per square foot for all CON-approved applications during 2012; source is Tennessee HSDA. VUMC costs for this project are higher when compared to the other recently approved Tennessee CON projects due to the higher construction costs involved with facilities, mechanical requirements and construction over existing patient care areas.

Hospital Construction Cost per Square Foot
Approved Projects, 2010-2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

4. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

RESPONSE:

Average Gross Charge	**$80,944**
Average Deduction from Operating Revenue	**$55,503**
Average Net Charge	**$25,441**

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		FY11	FY12	FY13
A.	Utilization Data	82.3%	81.2%	81.0%
B.	Revenue from Services to Patients			
1.	Inpatient Services	$2,958,557,574	$2,946,427,273	$3,521,619,463
2.	Outpatient Services	$1,996,237,552	$2,284,864,589	$1,878,519,497
3.	Emergency Services	$172,746,469	$222,701,528	$236,435,402
4.	Other Operating Revenue	$13,817,470	$11,755,661	$12,678,329
	Gross Operating Revenue	$5,141,359,065	$5,465,749,051	$5,649,252,691
C.				
1.	Contractual Adjustments	$2,999,262,282	$3,157,381,889	$3,409,755,679
2.	Provision for Charity Care	$278,807,927	$312,846,669	$374,555,880
3.	Provisions for Bad Debt	$92,620,466	$90,645,441	$51,130,366
	Total Deductions	$3,370,690,675	$3,560,873,999	$3,835,441,925
NET OPERATING REVENUE		$1,770,668,390	$1,904,875,052	$1,813,810,766
D.	Operating Expenses			
1.	Salaries and Wages	$489,548,937	$535,813,562	$567,485,073
2.	Physician's Salaries and Wages	$83,324,502	$95,493,800	$103,731,792
3.	Supplies	$329,166,755	$362,423,688	$410,504,178
4.	Taxes	$488,370	$553,109	$155,380
5.	Depreciation	$67,575,449	$67,543,321	$68,879,764
6.	Rent	$18,375,582	$18,112,703	$18,764,661
7.	Interest, other than Capital			
8.	Management Fees:	$-	$-	$-
a.	Fees to Affiliates			
b.	Fees to Non-Affiliates			
9.	Other Expenses (Specify)	$624,633,138	$649,491,163	$598,172,065
	Total Operating Expenses	$1,613,112,733	$1,729,431,346	$1,767,692,913
E.	Other Revenue (Expenses) – Net	$2,105,590	$1,201,758	$2,125,812
NET OPERATING INCOME (LOSS)		$159,661,247	$176,645,464	$48,243,665
F.	Capital Expenditures			
1.	Retirement of Principal	$12,385,000	$21,716,763	$23,544,334
2.	Interest	$44,481,069	$50,747,353	$47,900,462
	Total Capital Expenditures	$56,866,069	$72,464,116	$71,444,796
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$102,795,178	$104,181,348	$(23,201,131)

OTHER EXPENSES CATEGORIES	FY11	FY12	FY13
1. General and Administrative	$224,821,789	$233,768,841	$215,297,757
2. Fringe Benefits	$64,789,396	$67,367,768	$62,044,750
3. Interest/ Lease	$58,437,499	$60,763,089	$55,961,935
4. Equipment	$51,363,386	$53,407,454	$49,187,501
5. Laundry and Housekeeping	$31,748,741	$33,012,221	$30,403,783
6. Plant Operations	$16,769,466	$17,436,827	$16,059,068
7. Other Expenses	$176,702,860	$183,734,962	$169,217,271
Total Other Expenses	$624,633,138	$649,491,163	$598,172,065

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in ___July___ (Month).

		FY20	FY21
A.	Utilization Data (Discharges)	6,508	7,957
B.	Revenue from Services to Patients		
1.	Inpatient Services	$526,761,395	$634,528,915
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue		
	Gross Operating Revenue	**$526,761,395**	**$634,528,915**
C.	Deductions for Operating Revenue		
1.	Contractual Adjustments	$316,122,488	$383,284,043
2.	Provision for Charity Care	$41,836,664	$51,659,660
3.	Provisions for Bad Debt	$3,240,882	$3,977,397
	Total Deductions	**$361,200,034**	**$438,921,099**
NET OPERATING REVENUE		$165,561,361	$195,607,816
D.	Operating Expenses		
1.	Salaries and Wages	$36,469,199	$42,798,665
2.	Physician's Salaries and Wages		
3.	Supplies (Medical Supplies & Services)	$27,100,691	$33,360,491
4.	Taxes		
5.	Depreciation	$5,376,225	$5,376,225
6.	Rent		
7.	Interest, other than Capital		
8.	Other Expenses	$53,040,152	$64,273,715
	Total Operating Expenses	**$121,986,268**	**$145,809,097**
E.	Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)		$43,575,093	$49,798,719
F.	Capital Expenditures		
1.	Retirement of Principal	$2,712,000	$2,915,000
2.	Interest	$5,044,000	$4,841,000
	Total Capital Expenditures	**$7,756,000**	**$7,756,000**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$35,819,093**	**$42,042,719**

OTHER EXPENSES CATEGORIES		FY20	FY21
1.	General and Administrative	$19,090,537	$23,133,790
2.	Fringe Benefits	$5,501,532	$6,666,722
3.	Interest/ Lease	$4,962,167	$6,013,122
4.	Equipment	$4,361,475	$5,285,207
5.	Laundry and Housekeeping	$2,695,915	$3,266,893
6.	Plant Operations	$1,423,964	$1,725,550
7.	Other Expenses	$15,004,562	$18,182,432
	Total Other Expenses	$53,040,152	$64,273,715

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: Average charges for the project can be derived from historic utilization experience and this method was used to obtain the anticipated charges and revenue for the proposed project provided in the Projected Data Chart. The average gross charge being performed in the proposed project is $80,944 while the average net revenue per case is $25,441. There should be no adjustments to current charges based on implementation of this project.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: The Medicare payment rate for the top CPT codes that will be performed is provided below.

CPT Code	Description	Rate
99231	SBSQ HOSPITAL CARE/DAY 15 MINUTES	$37.49
99232	SBSQ HOSPITAL CARE/DAY 25 MINUTES	$68.99
59400	ROUTINE OB CARE INCL ANTEPARTUM CARE-VAG DEL-P	$1,963.71
99213	OFFIC/OUTPT VISIT E&M EST LOW-MOD SEVERITY 15M	$68.23
59025	FETAL NON-STRESS TEST	$44.08
59025TC	FETAL NON-STRESS TEST	$16.27
5902526	FETAL NON-STRESS TEST	$27.81
59410	VAG DELIV ONLY; INCL PP CARE	$983.37
59515	C DELIV ONLY; INCL PP CARE	$1,188.79
54150	CIRCUMCISION USING CLAMP/OTHER DEVICE; NB	$144.25
99233	SBSQ HOSPITAL CARE/DAY 35 MINUTES	$99.45
59510	ROUTINE OB CARE INCL ANTEPARTUM CARE-C SECT-PP	$2,168.64
99238	HOSP D/C DA MGMT; 30 MIN/LESS	$69.04
99223	INITIAL HOSPITAL CARE/DAY 70 MINUTES	$193.72
58611	LIG/TRANSECT FALLOPIAN TUBE-W/C SECT/INTRA-ABD	$74.92
58558	HYSTEROSCOPY, BIOPSY	$370.83
59514	C DELIV ONLY;	$867.34
99220	INITIAL OBSERVATION CARE HIGH SEVERITY	$177.20
99222	INITIAL HOSPITAL CARE/DAY 50 MINUTES	$131.22
99217	OBSERVATION CARE DISCHARGE MANAGEMENT	$68.91
99232	SUBSQT HOSP CARE-DA E&M MINOR COMPLIC 25 MIN	$68.99
99221	INITIAL HOSPITAL CARE/DAY 30 MINUTES	$96.42

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: The proposed project will improve operational efficiency on the main VUH campus. As indicated in the Projected Data Chart, projected utilization will allow VUMC to maintain cost-effectiveness.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved

RESPONSE: The proposed utilization rate provides a positive cash flow in Year 1.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In

addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: Please see the chart provided below.

	FY12		FY13		FY20		FY21	
	Revenue	% of Total	Revenue	% of Total	Revenue	% of Total	Revenue	% of Total
Medicare	$ 1,094,974,255	20%	$ 1,123,426,447	19%	$ 141,433,114	27%	$ 174,462,488	27%
Medicaid	$ 993,426,703	18%	$ 1,025,612,778	18%	$ 105,933,190	20%	$ 120,012,422	19%
Bad Debt	$ 90,645,441	2%	$ 95,059,002	2%	$ 3,238,430	1%	$ 3,977,397	1%
Charity Care	$ 312,846,669	6%	$ 330,627,244	6%	$ 41,803,738	8%	$ 51,659,660	8%
Subtotal	$ 2,491,893,068	46%	$ 2,574,725,471	45%	$ 292,408,471	56%	$ 350,111,967	55%
Other	$ 2,962,100,322	54%	$ 3,188,321,967	55%	$ 234,352,923	44%	$ 284,416,949	45%
Total Gross Revenue	$ 5,453,993,390	100%	$ 5,763,047,438	100%	$ 526,761,395	100%	$ 634,528,915	100%

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility.10.

RESPONSE: See Attachment C, Economic Feasibility.10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

    RESPONSE: Several construction alternatives were explored during the planning of this project. One such alternative included the idea of vertical expansion of The Vanderbilt Clinic building. However, the expense of this option was not an efficient use of funds given the limited number of beds and programmatic components needed. The Vanderbilt Clinic building is rated as business occupancy rather than institutional occupancy which would require additional expense to bring in to compliance with regulations.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

    RESPONSE: Please see Attachment C. Contribution to the Orderly Development of Healthcare.1

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

RESPONSE: The proposed project will improve access to care by allowing VUMC to expand capacity of the subspecialty care available in order to meet current and future demand. Recent Blue Cross Blue Shield of Tennessee white paper evidences the in-migration to major referral centers from the outlying areas. In Vanderbilt's case, much of this in-migration is no doubt a product of the complete array of subspecialties available at both VUH and MCJCHV.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

   RESPONSE: The staffing for this project is provided below.

   Registered Nurse (RN) 243
   Medical Receptionist (MR) 38
   Care Partner (CP) 62

   The salaries proposed for the clinical staff positions are anticipated to be comparable to the rates provided in the TN Department of Labor & Workforce Development Occupational Employment Statistics Survey.

Staff Position	VUMC	Mean	25th Percentile	Median	75th Percentile
Registered Nurse	$33.14	$31.00	$23.65	$28.90	$34.75
Medical Receptionist*	$16.23	$15.00	$12.00	$14.60	$17.50
Care Partner**	$47.48	$45.15	$30.95	$39.40	$53.75

Hourly Rate - Occupational Employment Statistics Survey Data for 2012 in Nashville-Davidson--Murfreesboro, TN MSA
**Rates compared with Healthcare Support Workers, All Other*
***Rates compared with Medical Assistant*

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

   RESPONSE: Vanderbilt University Medical Center will staff the facility. Vanderbilt University Medical Center and Vanderbilt University are uniquely partnered to provide a dynamic recruitment and retention program for employees. As the largest Nashville employer, other than the State of Tennessee, we actively search for the most appropriate candidates and seek to place them in career successful positions. Recruitment of technical and professional staff for the project is not expected to be a problem given the desirable employment environment and benefit structure at Vanderbilt.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education

   RESPONSE: Vanderbilt University Medical Center will be responsible for credentialing, quality assurance, and staff education.

   Credentialing

The Provider Support Services department credentials all providers that will admit patients to VUMC or attend to patients at VUMC and its satellite locations. Documents are verified from the primary source and include medical or professional licenses, DEA status (if applicable), malpractice insurance and claims history, appropriate schooling, board certification and faculty status. Once all documents have been verified, they are presented to the Credentials Committee for review and recommendation to the Medical Center Medical Board. The Medical Center Medical Board then recommends approval to the Board of Trust, which makes the final decision.

Quality Assurance

VUMC's Performance Improvement and Safety Plan is framed around the Institute of Medicine's (IOM) Quality Chasm Report. It incorporates the IOM Six Aims for Improvement (i.e. care that is safe, timely, efficient, effective, equitable, and patient-centered). The fundamental integrity of the Plan is based on the pivotal roles played by the VU Board of Trust, the Medical Center Medical Board, and the VUMC Quality Council (which is chaired by the Associate Vice Chancellor) in ensuring an effective, hospital-wide effort.

The Performance Improvement Plan incorporates the traditional quality control/quality assurance monitors as well as leadership-defined, performance improvement initiatives tied to the institution's Strategic Plan. Significant resources are devoted to implementing the plan through the Center for Clinical Improvement and the Accreditation and Standards Departments. The plan is reviewed and revised annually based upon senior leadership's assessment of effectiveness.

In addition, each year an Employee Performance Competency Report is issued to the Board of Trust, which is reviewed in accordance with administrative policy and JCAHO standards. This report includes competency maintenance activities that are required on a yearly basis for all employees. For those that are not up to the required standards, performance improvement efforts are implemented with customized plans to meet individual staff needs. Those that do not meet the objectives of the improvement plan are terminated for cause.

Staff Education

VUMC devotes a variety of resources to the development of staff at all levels of the organization. VUMC's Learning Center provides comprehensive orientation and role specific training to help new staff become successful in their jobs. In partnership with Environmental Health Services, Offices for Compliance and Accreditation, the Learning Center assists all staff in meeting competencies and regulatory requirements. Other programs enable individual staff to develop collaborative teamwork skills, manage conflict, improve communication, precept other staff or fulfill roles of responsibility within their work groups.

Radiology, Nursing, Pharmacy, Nutrition Services, and Rehabilitation Services Departments are leaders in providing continuing education for their staff. Programs are offered centrally and in unit and discipline-specific forums. Managers and administrators are supported in developing financial skills by VUMC's Department of Finance, which has its own training division. In addition, nursing managers are supported through a development program in conjunction with the Health Care Advisory Board and the Learning Center.

As employees of Vanderbilt University, VUMC staff has access to a variety of training classes offered by Human Resource Services. The classes are divided into four series, grouped by the type of skills that are emphasized: Leadership, Business/Interpersonal, Administrative, and Individual Growth and Development. HRS also provides customized training and facilitation classes for individual teams.

The Department of Systems Support provides the technical training to implement the many state-of-the-art patient information systems used in daily patient care. Finally, many tools and resources are available on-line at the Learning Center, Department of Finance and Human Resources websites.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

   RESPONSE: VUMC has accredited training programs in medicine, radiation oncology (residents), medical physicists and dosimetrists, nursing, pharmacy, respiratory therapy, dietetics, medical technology, radiation therapy technology, cardiovascular perfusion technology and nuclear medicine technology. VUMC is also a major clinical training facility for Vanderbilt University Medical and Nursing Schools. VUMC supports a total house staff training program of 697 residents and 279 fellows.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

   RESPONSE: The proposed facility will be constructed and operated to comply with all existing codes and license requirements.

   (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

   RESPONSE: Licensure: State of Tennessee, Department of Health Facilities, Licensure Division

   (c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

   RESPONSE: Please see Attachment C. Contribution to the Orderly Development of Healthcare.7.c

   (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

   RESPONSE: Please see Attachment C. Contribution to the Orderly Development of Healthcare.7.d

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

   RESPONSE: Not Applicable

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

   RESPONSE: Not Applicable

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

RESPONSE: If this proposal is approved, Vanderbilt University Hospital will provide the Tennessee Health Services and Development Agency with information concerning the number of patients treated, the number and type of procedures performed and other requested data.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): September 2014
Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	30	October 2014
2. Construction documents approved by the Tennessee Department of Health	30	October 2014
3. Construction contract signed	30	October 2014
4. Building permit secured	30	October 2014
5. Building construction commenced	120	January 2015
6. Construction 40% complete	426	December 2015
7. Construction 80% complete	1,308	May 2018
8. Construction 100% complete-approved for occupancy	1,612	March 2019
9. *Issuance of license	1,657	April 2019
10. *Initiation of service	1,672	April 2019
11. Final Architectural Certification of Payment	1,703	May 2019
12. Final Project Report Form (HF0055)	1,703	May 2019

***For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

Ginna Felts, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Ginna Felts
Business Development

Sworn to and subscribed before me this 12th day of June, 2014, a Notary
(Month)(Year)

Public in and for the County/State of Davidson County, Tennessee.

Jennifer Hygrell
NOTARY PUBLIC

My commission expires May 5, 2015.
(Month/Day) (Year)

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

Vanderbilt University Medical Center CON
Application Attachments
(in order of appearance)

Corporate Charter & Cert of Existence: Attachment A.3

Org Chart and Ownership List: Attachment A.4

Title/Deed: Attachment A.6

VUH MCO Contracts and Networks: Attachment A.13

Plot Plan: Attachment B.Project Description.III.A

Floor Plan: Attachment B.Project Description.IV

Service Area Map: Attachment C.Need.3

Primary Service Area Demographic Chart: Attachment C.Need.4.A

Estimated Construction Cost Letter: Attachment C.Economic Feasibility.1

Funding Documentation (proof of cash reserves): Attachment C.Economic Feasibility.2

VUMC Financial Statements: Attachment C.Economic Feasibility.10

Contracts: Attachment C.Contribution to the Orderly Development of Healthcare.1

Licensure & Accreditation: Attachment C.Contribution to the Orderly Development of Healthcare.7.c

Licensure Certification & Plan of Correction: Attachment C.Contribution to the Orderly Development of Healthcare.7.d

Proof of publication

Attachment A.13

Vanderbilt University Hospitals MCO Contracts and Networks

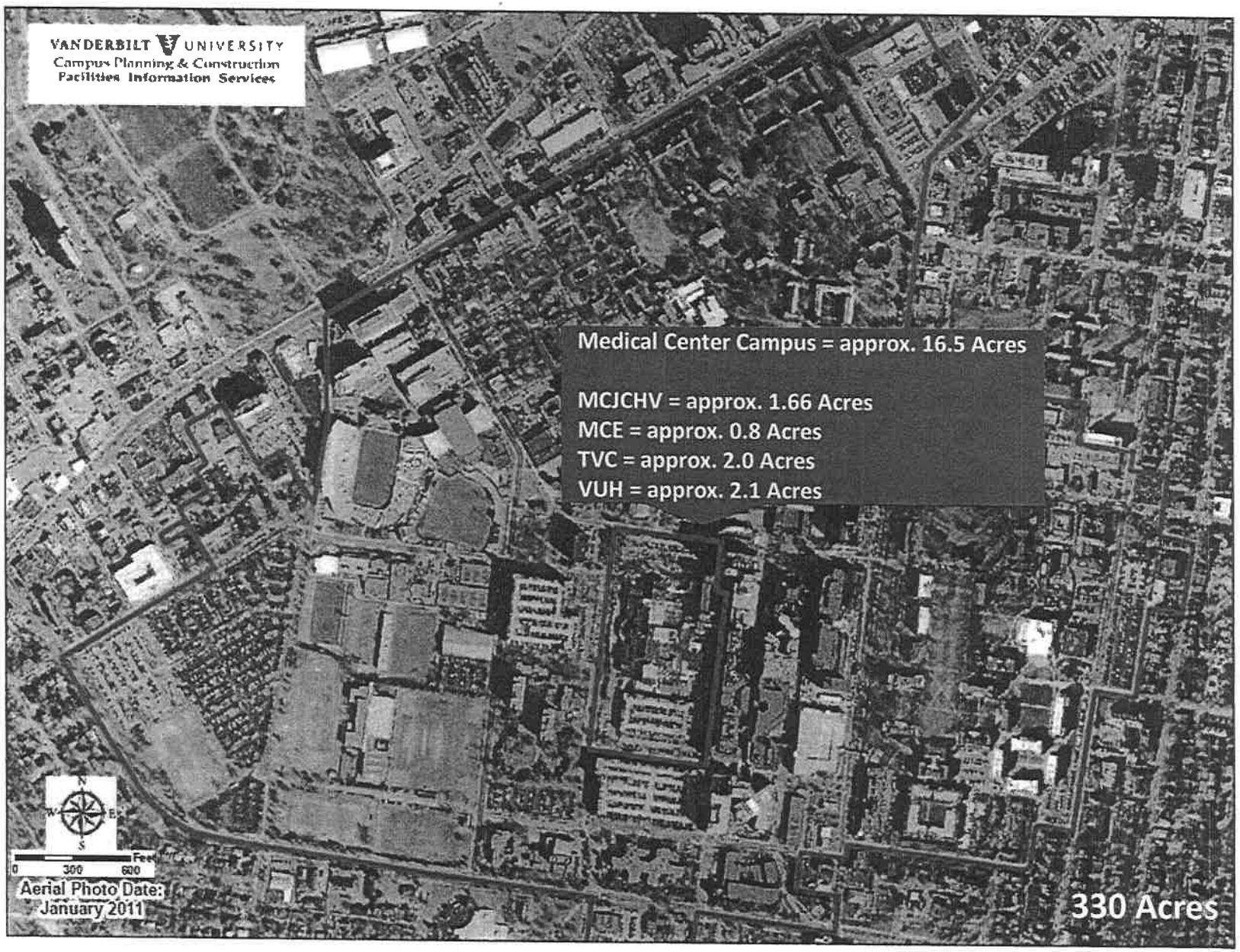
Attachment A.13
VUH/VCH Contracts & Networks

- Aetna/US Healthcare
- AmeriGroup Community Care*
- Blue Cross Blue Shield of Tennessee/Magellan
- Bluegrass Family Health
- CIGNA Behavioral Health
- Center Care
- Community Care Network Methodist Hospital
- Cigna HealthCare/Great West
- Correct Care Solutions
- Corvel Workman's Comp
- Coventry Cares
- Coventry Health
- Health Partners
- HealthSpring
- HealthNet Federal Services (Tricare)
- Health One Alliance / Alliant Health Plan
- Humana, Inc.
- Humana Military
- CrestPoint ISHN
- Magellan Health
- NovaNet PPO
- Owensboro Community Health Network
- Private Healthcare Systems, Inc. (PHCS)
- Prime Health
- Signature Health Alliance
- United Behavioral Health
- United BH/Community Plan*
- United Healthcare
- UnitedHealthCare Community Plan*
- USA MCO
- ValueOptions*
- BlueCare/TennCare*
- WellCare
- Windsor Health Group

Items noted with an * are TennCare MCOs

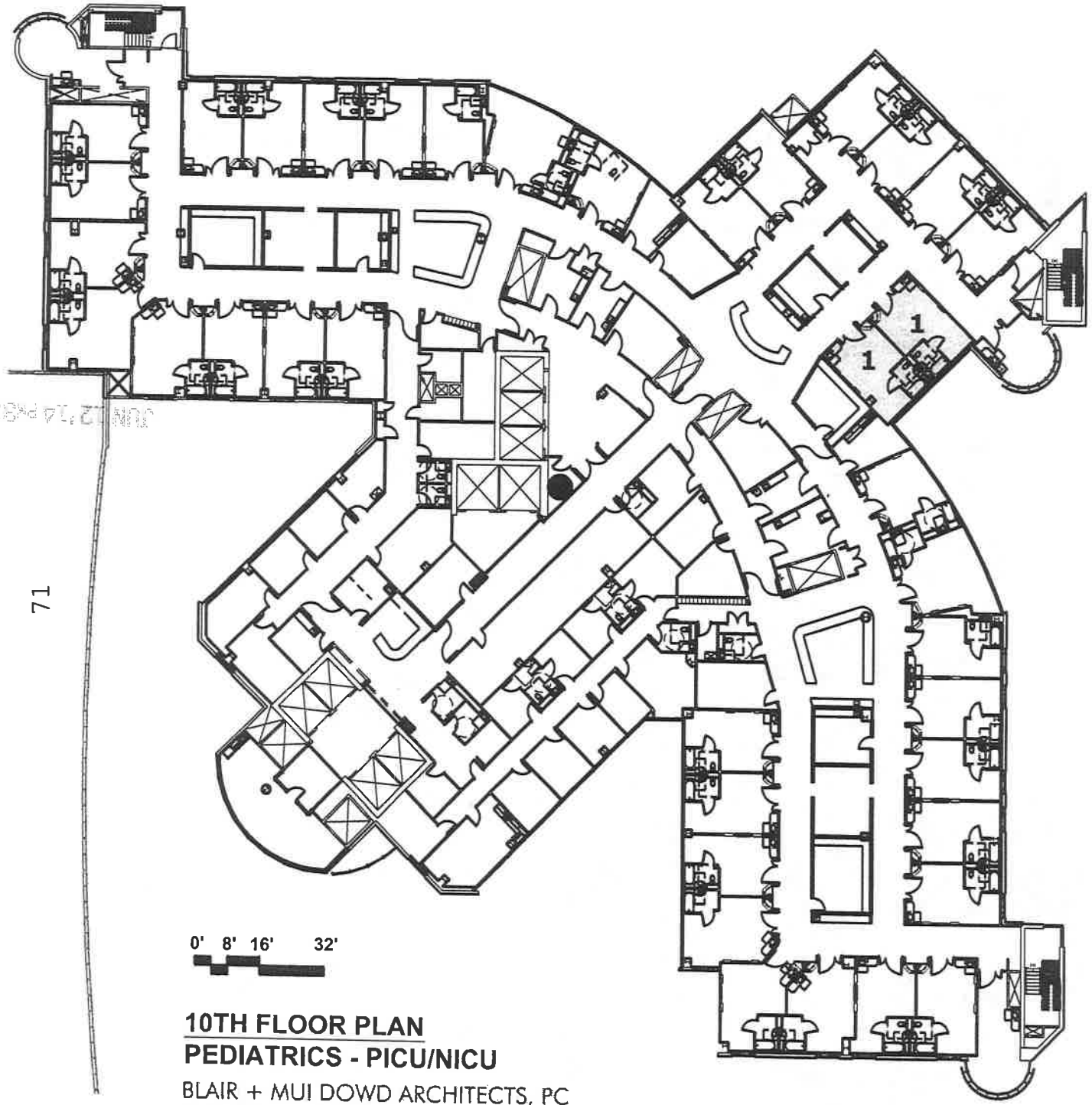
Attachment B.Project Description.III.A

Plot Plan


VANDERBILT UNIVERSITY
Campus Planning & Construction
Facilities Information Services
Medical Center Campus = approx. 16.5 Acres
MCJCHV = approx. 1.66 Acres
MCE = approx. 0.8 Acres
TVC = approx. 2.0 Acres
VUH = approx. 2.1 Acres
N
W
E
S
0
300
600
Feet
Aerial Photo Date:
January 2011
330 Acres

Attachment B.Project Description.IV

Floor Plan

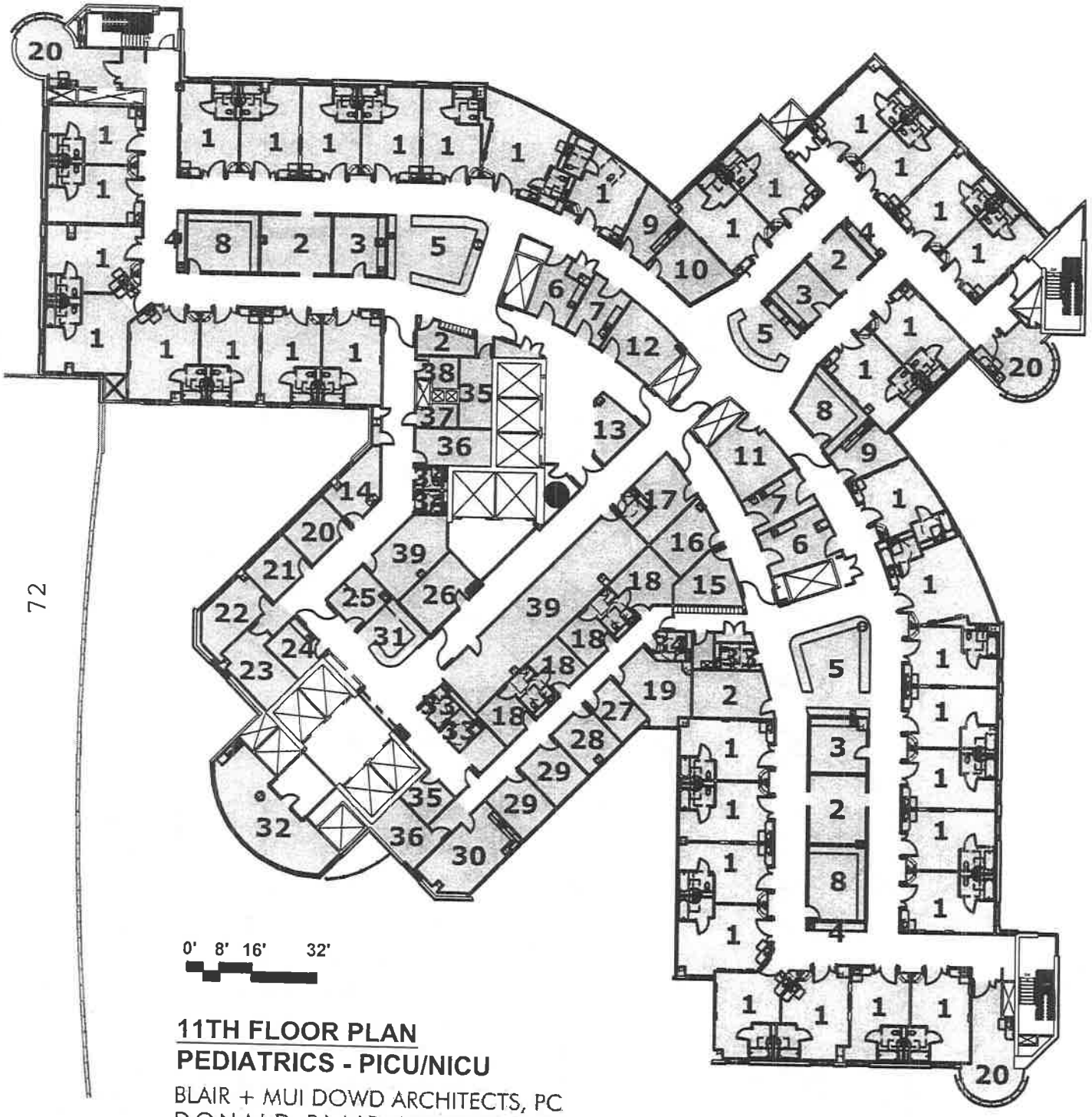


PROGRAM - PATIENT ROOMS

1. NICU/CRITICAL CARE ROOMS - (2)

10TH FLOOR PLAN
PEDIATRICS - PICU/NICU

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS



11TH FLOOR PLAN
PEDIATRICS - PICU/NICU

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS

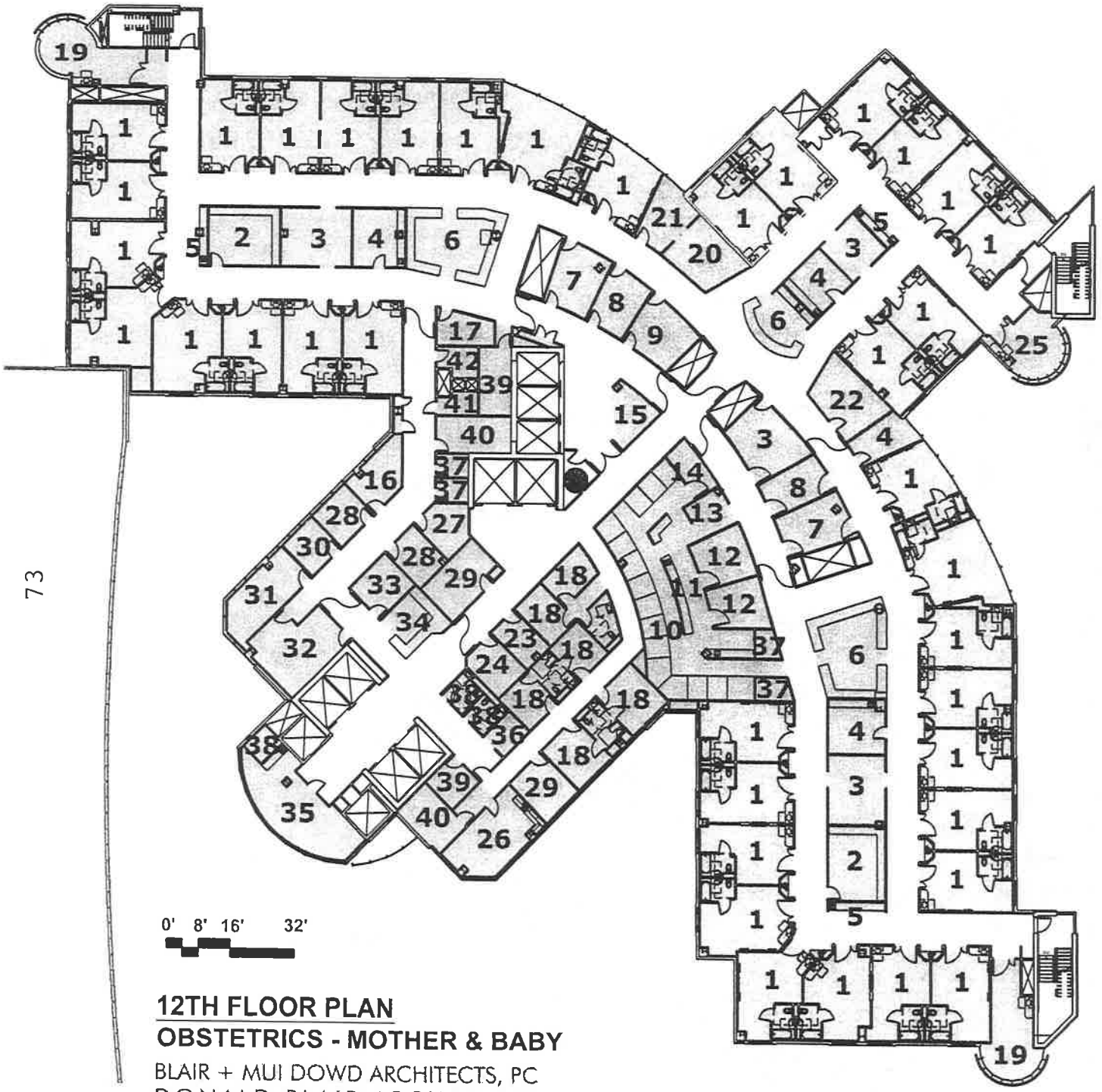
PROGRAM - PATIENT ROOMS
1. PEDIATRIC PATIENT ROOMS - (38)

PROGRAM - CORE SUPPORT
2. EQUIPMENT STORAGE (4)
3. MEDICATION ROOM (3)
4. PANTRY/NOURISHMENT (3)
5. NURSE STATION (3)
6. CLEAN UTILITY (2)
7. SOILED UTILITY (2)
8. TEAM WORK ROOM (3)
9. BREAK ROOM (2)
10. TRAINING ROOM (1)
11. TREATMENT ROOM (1)
12. PHARMACY (1)
13. X-RAY STORAGE (1)
14. EVS HOUSEKEEPING (1)
15. ECMO STORAGE & LAB (1)
16. FORMULA PREP (1)
17. RT LAB & STORAGE (1)
18. ON CALL ROOM (4)
19. RESIDENTS WORK ROOM (1)

PROGRAM - ADMINISTRATIVE SUPPORT
20. GENERAL OFFICE (1)
21. ANX SUPPORT OFFICE (1)
22. CSLS & AA OFFICE (1)
23. NNP OFFICE (1)
24. LAUNDRY (1)
25. LACTATION ROOM (1)
26. PLAY ROOM (1)
27. UNASSIGNED OFFICE (1)
28. ATTENDING OFFICE (1)
29. MANAGER OFFICE (2)
30. CONFERENCE ROOM (1)
31. CONCIERGE DESK (1)
32. FAMILY LOUNGE (1)
33. PUBLIC TOILET (3)
34. STAFF TOILET (3)

PROGRAM - UTILITIES
35. ELECTRICAL ROOM (2)
36. DATA ROOM (2)
37. LINEN (1)
38. TRASH (1)

39. SHELL



0' 8' 16' 32'

12TH FLOOR PLAN
OBSTETRICS - MOTHER & BABY

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS

PROGRAM - PATIENT ROOMS

1. MOTHER & BABY PATIENT ROOM - (38)

PROGRAM - CORE SUPPORT

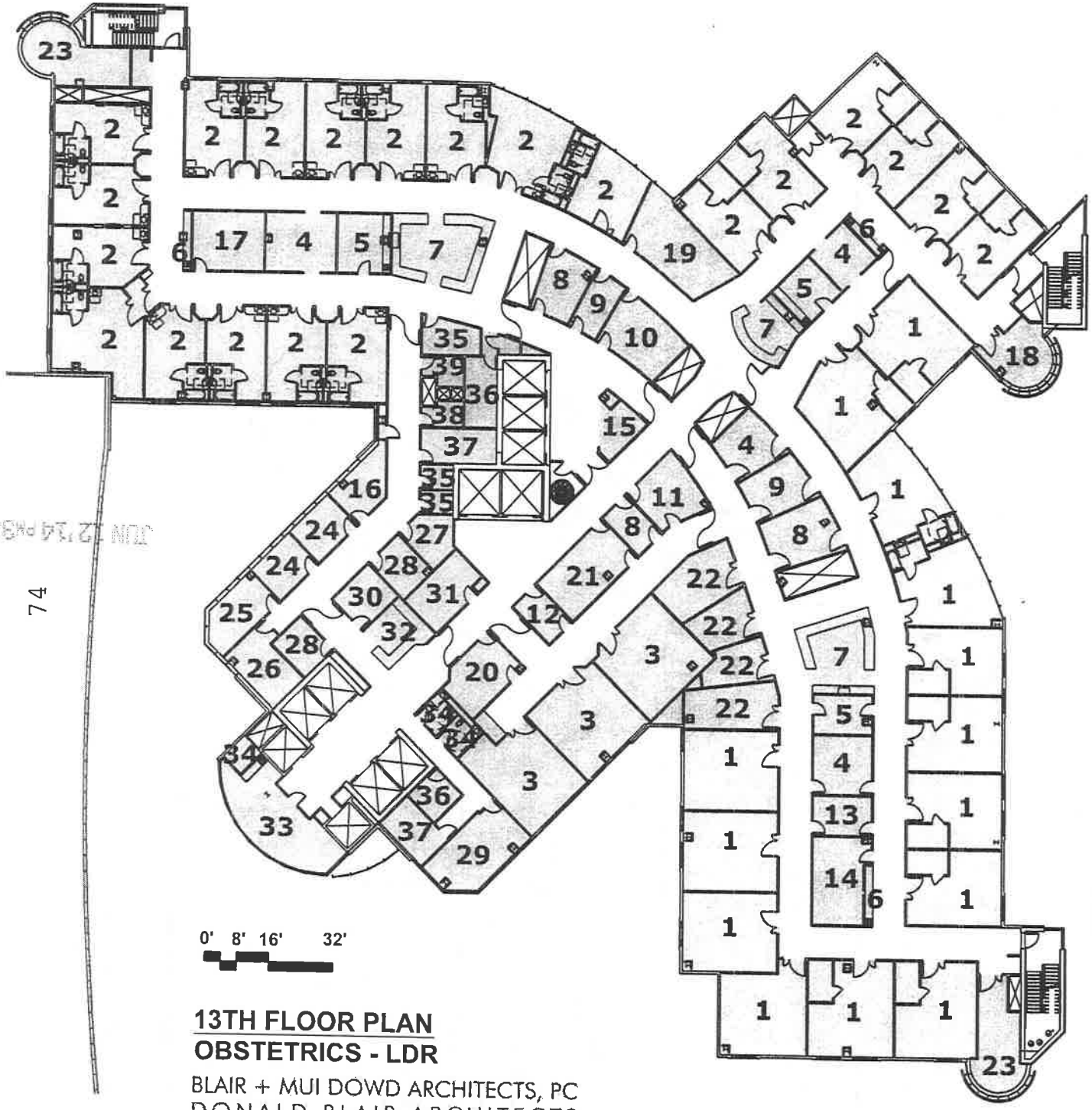
2. MULTIDISCIPLINARY TEAM ROOM (2)
3. EQUIPMENT STORAGE (3)
4. MEDICATION ROOM (3)
5. PANTRY/NOURISHMENT (3)
6. NURSE STATION (3)
7. CLEAN UTILITY (2)
8. SOILED UTILITY (2)
9. STAFF LOCKERS (1)
10. NEWBORN NURSERY (1)
11. NURSERY WORK AREA (1)
12. EXAM/TREATMENT AREA (2)
13. SCRUB & GOWN AREA (1)
14. LACTATION SUPPORT ROOM (1)
15. DIETARY CART (1)
16. EVS HOUSEKEEPING (1)
17. BREASTMILK/FORMULA STORAGE (1)
18. ON CALL WITH SHARED TOILET (6)

PROGRAM - ADMINISTRATIVE SUPPORT

19. CONSULT ROOM (2)
20. CELEBRATION ROOM (1)
21. CLASSROOM (1)
22. STAFF LOUNGE (1)
23. HEARING TESTING (1)
24. PHOTOGRAPHY ROOM (1)
25. RESIDENTS LOUNGE (1)
26. CONFERENCE ROOM (1)
27. PRIVATE OFFICE (1)
28. MANAGERS OFFICE (2)
29. MEDICAL DIRECTORS OFFICE (2)
30. EDUCATOR OFFICE (1)
31. QUALITY CONSULTANTS OFFICE (1)
32. LACTATION CONSULTANTS (1)
33. LACTATION (1)
34. MEDICAL RECEPTION (1)
35. FAMILY LOUNGE (1)
36. VENDING (1)
37. STAFF TOILET (4)
38. VISITOR TOILET (3)

PROGRAM - UTILITIES

39. ELECTRICAL ROOM (2)
40. DATA ROOM (2)
41. LINEN (1)
42. TRASH (1)



PROGRAM - PATIENT ROOMS

1. LDR ROOM - (14)
2. ANTE/POSTPARTUM ROOM - (21)

PROGRAM - CORE SUPPORT

3. C-SECTION OPERATING ROOM (3)
4. EQUIPMENT STORAGE (4)
5. MEDICATION ROOM (3)
6. PANTRY/NOURISHMENT (3)
7. NURSE STATION (3)
8. CLEAN UTILITY (2)
9. SOILED UTILITY (2)
10. STAFF LOCKERS (1)
11. STERILE STORAGE (1)
12. SUB STERILE UTILITY (1)
13. ANESTHESIA WORKROOM (1)
14. LDR LOUNGE (1)
15. DIETARY CART (1)
16. EVS HOUSEKEEPING (1)
17. RESIDENTS SPACE (1)
18. RESIDENTS LOUNGE (1)
19. LDR STAFF GATHERING (1)
20. MALE PHYSICIAN LOCKERS (1)
21. FEMALE PHYSICIAN LOCKERS (1)
22. RECOVERY ROOM (4)

PROGRAM - ADMINISTRATIVE SUPPORT

23. CONSULT ROOM (2)
24. MEDICAL DIRECTORS OFFICE (2)
25. CHARGE NURSES OFFICE (1)
26. AA OFFICE (1)
27. MANAGERS OFFICE (1)
28. ASSISTANT MANAGERS OFFICE (2)
29. CONFERENCE ROOM (1)
30. BEREAVEMENT ROOM (1)
31. CHILDRENS PLAY AREA (1)
32. CONCIERGE DESK (1)
33. FAMILY LOUNGE (1)
34. PUBLIC TOILET (3)
35. STAFF TOILET (2)

PROGRAM - UTILITIES

36. ELECTRICAL ROOM (2)
37. DATA ROOM (2)
38. LINEN (1)
39. TRASH (1)

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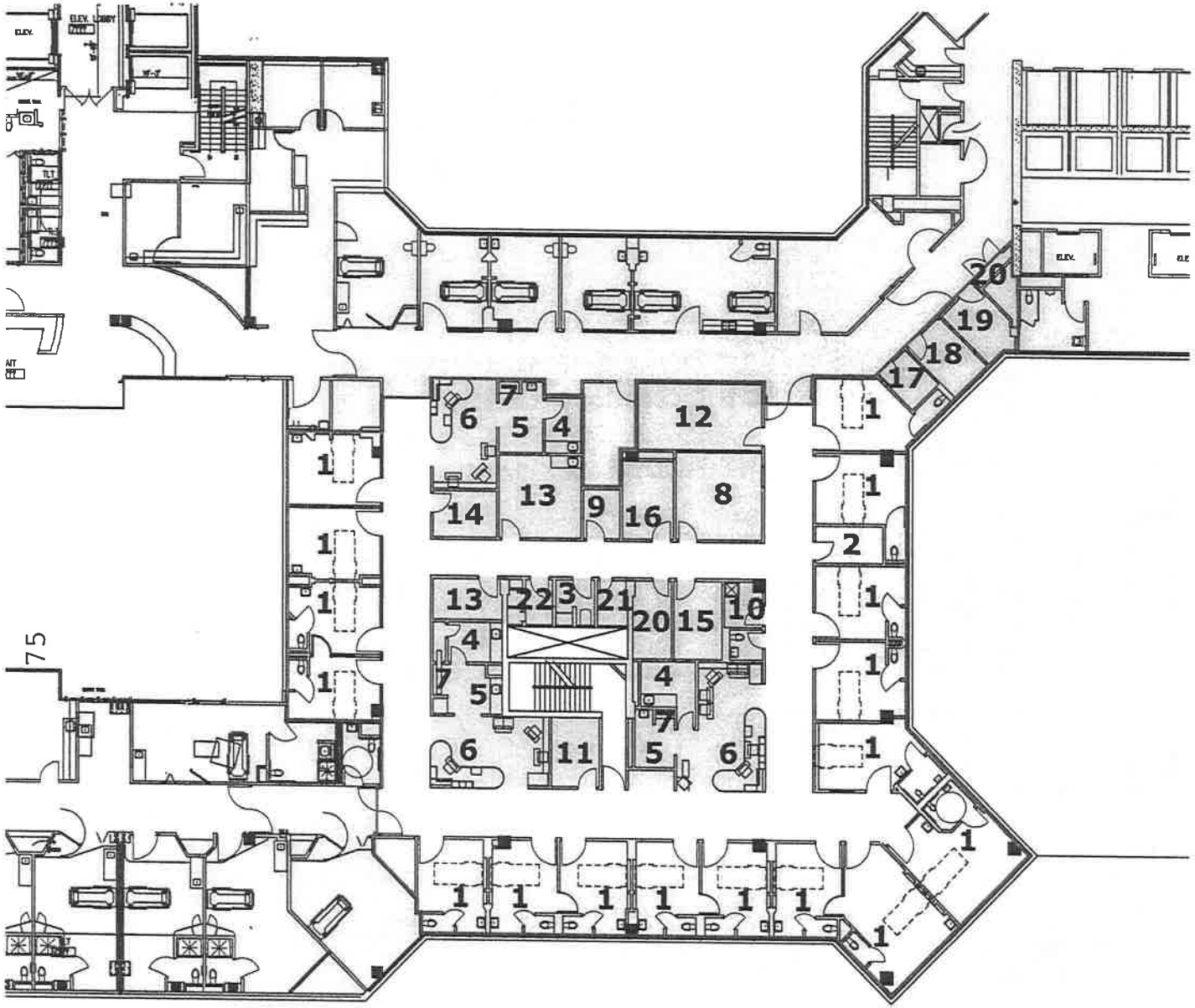
13TH FLOOR PLAN
OBSTETRICS - LDR

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS



0' 8' 16' 32'

VUH 7S FLOOR PLAN - OBSERVATION BEDS

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS

PROGRAM - PATIENT ROOMS

1. OBSERVATION PATIENT ROOM (17)

PROGRAM - CORE SUPPORT

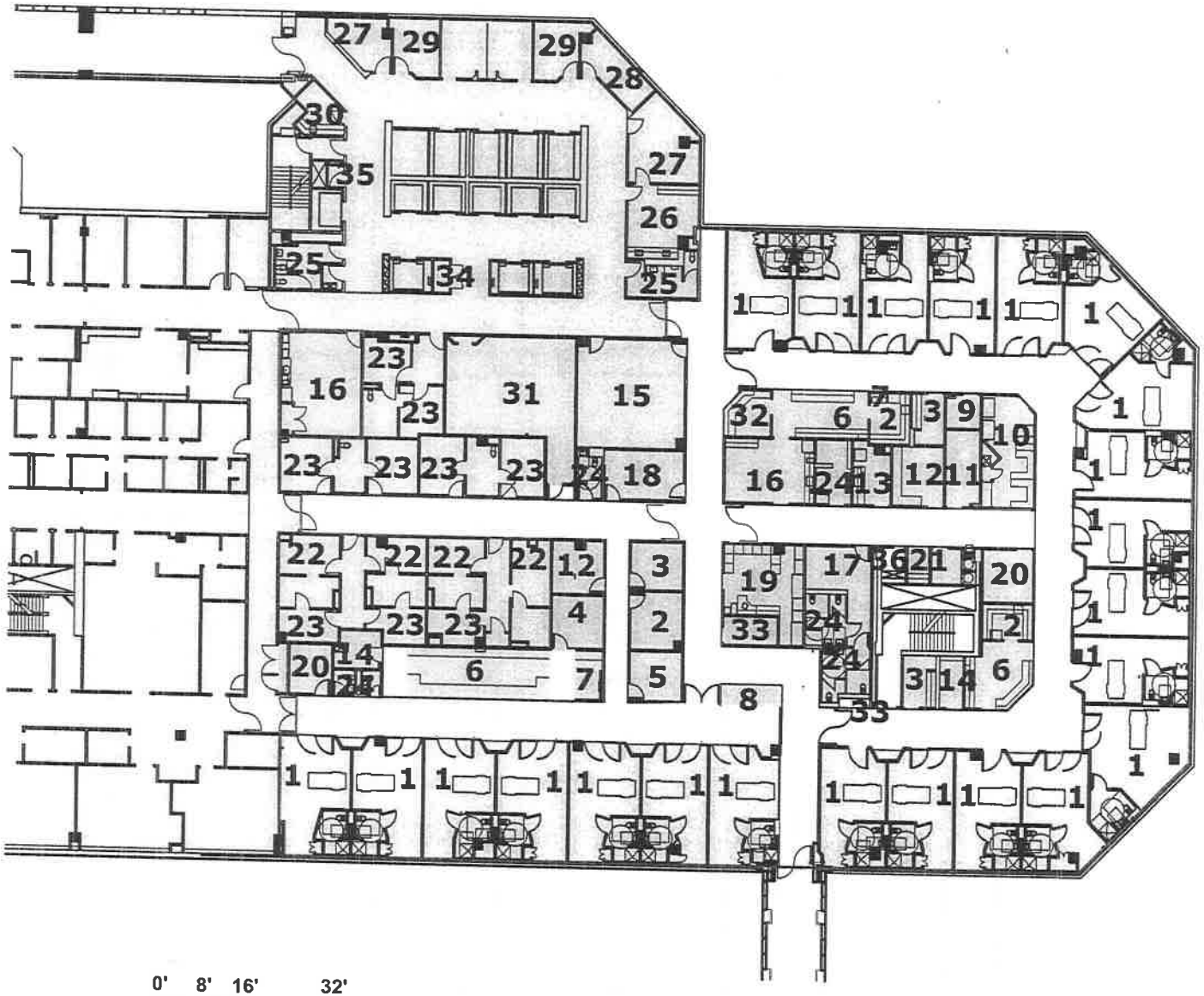
2. CLEAN WORKROOM (1)
3. SOILED WORKROOM (1)
4. MEDICATION ROOM (3)
5. ICE/NOURISHMENT/PANTRY (3)
6. NURSE STATION (3)
7. PNEUMATIC TUBE STATION(3)
8. STORAGE/ EQUIPMENT (1)
9. TRASH & SOILED LINEN (1)
10. EVS/HOUSEKEEPING (1)

PROGRAM - ADMINISTRATIVE SUPPORT

11. FAMILY LOUNGE (1)
12. STAFF LOUNGE (1)
13. CONFERENCE (1)
14. HEAD NURSE (1)
15. MALE STAFF TOILET/SHOWER (1)
16. FEMALE STAFF TOILET/ SHOWER (1)
17. RESIDENT OFFICE (1)
18. DIETARY (1)
19. FAMILY CONSULT (1)

PROGRAM - UTILITIES

20. ELECTRICAL (2)
21. TELECOM ROOM (1)
22. LINEN CHUTE (1)



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VUH 4N FLOOR PLAN - ADULT BEDS

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS

PROGRAM - PATIENT ROOMS

1. ADULT PATIENT BEDROOM (23)

PROGRAM - CORE SUPPORT

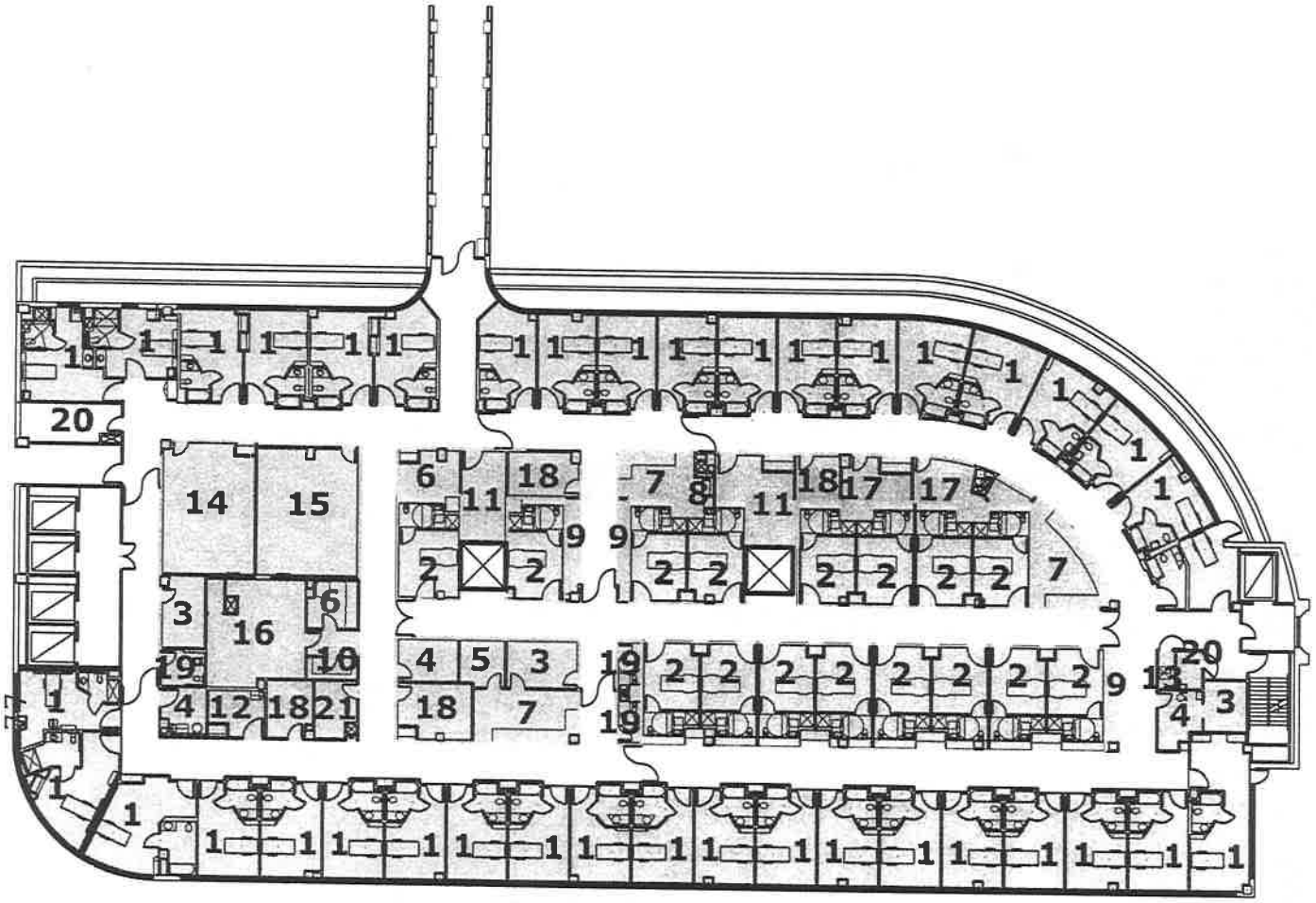
2. CLEAN WORKROOM (3)
3. SOILED WORKROOM (3)
4. MEDICATION ROOM (1)
5. ICE/NOURISHMENT (1)
6. NURSE STATION (3)
7. PNEUMATIC TUBE STATION(2)
8. ALCOVE (1)
9. STRETCHER/ CART STORAGE (1)
10. LINEN STORAGE (1)
11. STORAGE (1)
12. EQUIPMENT (2)
13. RETHERM (1)
14. EVS HOUSEKEEPING (2)

PROGRAM - ADMINISTRATIVE SUPPORT

15. FAMILY WAITING (1)
16. STAFF LOUNGE (2)
17. STAFF BREAKROOM/ LOCKERS (1)
18. MULTIPURPOSE ROOM (1)
19. SERVICE CENTER (1)
20. NURSE OFFICE (2)
21. COMPUTER ALCOVE (1)
22. ADA ON-CALL W/SHARED TOILET (4)
23. ON-CALL W/SHARED TOILET (9)
24. STAFF TOILET (6)
25. PUBLIC TOILET (2)
26. CLINICAL RESEARCH CORE (1)
27. ADMINISTRATIVE OFFICE (2)
28. MEDICAL RECORDS (1)
29. CONFERENCE (2)
30. STUDENT LAB (1)
31. AVAILABLE SPACE(1)
32. RECEPTION/ GREETER (1)

PROGRAM - UTILITIES

33. ELECTRICAL ROOM (2)
34. DATA ROOM (1)
35. TELECOM ROOM (1)
36. TELE-LIFT (1)



PROGRAM - PATIENT ROOMS

1. ADULT PATIENT BEDROOM (38)
2. OBSERVATION PATIENT ROOM (16)

PROGRAM - CORE SUPPORT

3. CLEAN WORKROOM (3)
4. SOILED WORKROOM (3)
5. MEDICATION ROOM (1)
6. ICE/NOURISHMENT/PANTRY (2)
7. NURSE STATION (3)
8. PNEUMATIC TUBE STATION (1)
9. ALCOVE (3)
10. STORAGE (1)
11. EQUIPMENT (2)
12. EXAM (1)
13. EVS/HOUSEKEEPING (1)

PROGRAM - ADMINISTRATIVE SUPPORT

14. FAMILY WAITING (1)
15. STAFF LOUNGE (1)
16. CONFERENCE (1)
17. NURSE OFFICE (2)
18. ADMINISTRATIVE OFFICE (4)
19. STAFF TOILET (3)

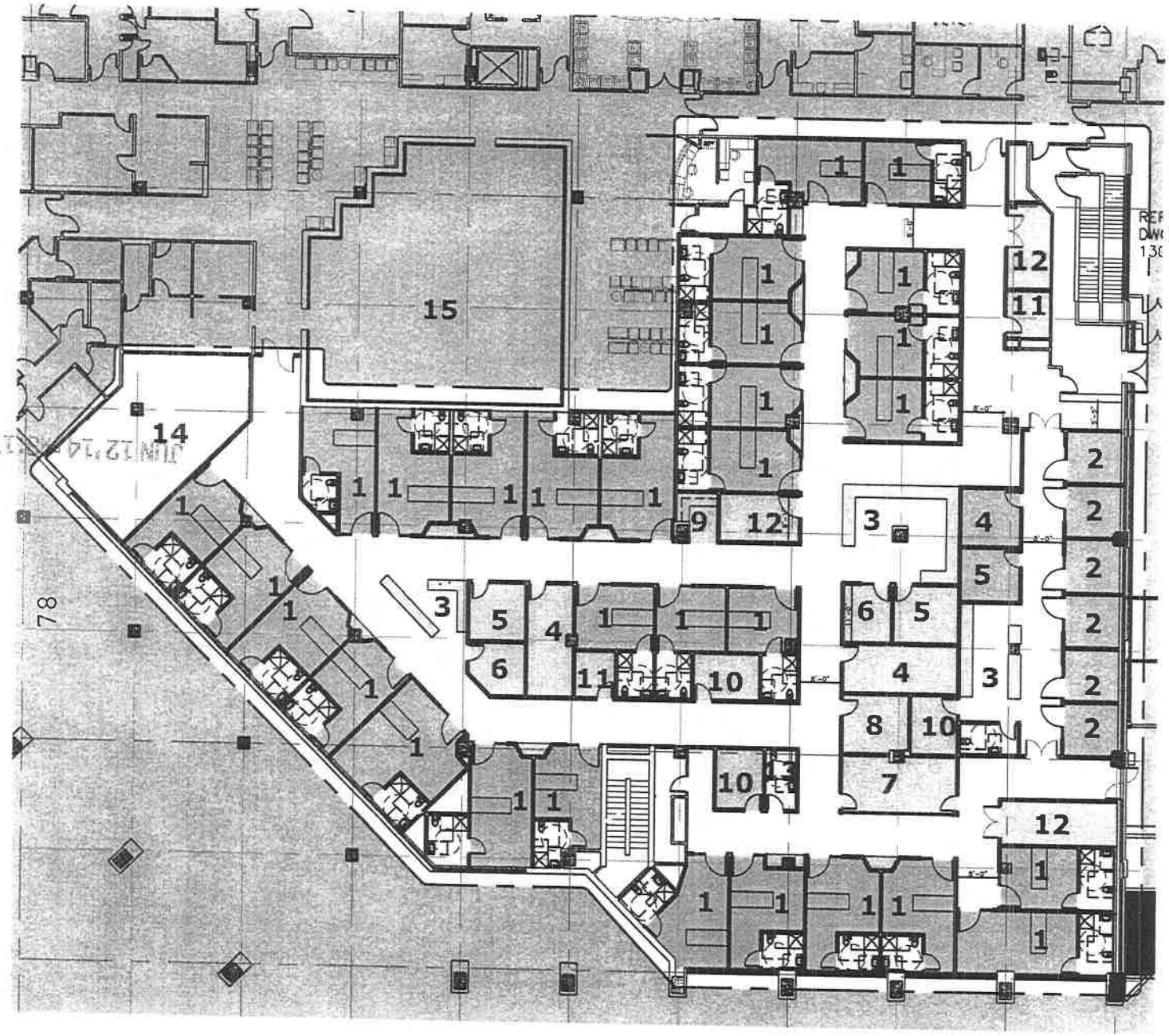
PROGRAM - UTILITIES

20. ELECTRICAL ROOM (2)
21. TELECOM ROOM (1)

0' 8' 16' 32'

MCE 4E FLOOR PLAN - ADULT BEDS & OBSERVATION BEDS

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS



PROGRAM - PATIENT ROOMS

1. PATIENT ROOM (30)
2. PSYCHIATRIC HOLDING ROOM (6)

PROGRAM - CORE SUPPORT

3. NURSE STATION (3)
4. CLEAN ROOM (3)
5. SOILED ROOM (3)
6. MEDICATION ROOM (2)
7. TEAM ROOM (1)
8. BREAK ROOM (1)
9. NOURISHMENT STATION (1)
10. OFFICE (3)
11. ENVIRONMENTAL SERVICES (2)
12. EQUIPMENT STORAGE (3)
13. STAFF TOILET (1)

PROGRAM - OTHER

14. FUTURE EXPANSION FOR PHLEBOTOMY
15. COURTYARD

1ST FLOOR - THE VANDERBILT CLINIC

0' 8' 16' 32'

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS

Attachment C.Need.3

Service Area Map

Service Area Map

Attachment C.Economic Feasibility.1

Estimated Construction Cost Letter

Turner

Turner Construction Company
5300 Virginia Way
Brentwood, TN 37027
phone: 615.231.6300
fax: 615.231.6301

June 1, 2014

To Whom It May Concern:

Subject: Vanderbilt University Medical Center
CON Application
Verification of Construction Cost Estimate

Turner Construction Company is a construction company in Nashville, Tennessee, and has reviewed the preliminary design for the above referenced project.

After reviewing this data, it is our opinion at this time that the projected construction cost of $77,126,075 is reasonable for this type and size of project and for the scope of work and compares similarly to other projects in the same market. It should also be noted, however, that construction costs continue to increase rapidly due to economic factors in the marketplace.

Yours Truly,

Randy Keiser
Vice President

Attachment C. Economic Feasibility.2

Funding Documentation

VANDERBILT UNIVERSITY MEDICAL CENTER

Cecelia B. Moore
Associate Vice Chancellor for Finance
Vanderbilt University Medical Center

June 12, 2014

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson State Office Bldg.
Suite 850
500 Deaderick St.
Nashville, TN 37243

Dear Ms. Hill:

This letter will confirm that Vanderbilt University by and through its Vanderbilt University Medical Center has financing resources sufficient to fund the project described in this Certificate of Need application. Funding of the project will be provided through a combination of capital resources, including tax-exempt debt and cash reserves.

As evidence of Vanderbilt's ability to provide the necessary capital, the following information is offered.

1. As of June 30, 2013, Vanderbilt held cash and unrestricted investments with a fair market value of $3.0 billion.
2. Vanderbilt has current credit ratings of Aa2/AA+/AA by Moody's/Fitch/S&P.
3. For additional financial information regarding Vanderbilt, please visit the following website: www.vanderbilt.edu/divadm/finrprt

Vanderbilt expects to finance the project with generated and/or borrowed funds to ensure that adequate funds will be available for the project at a reasonable cost. At the discretion of Vanderbilt, financing for part of the cost of the project may be obtained from publicly issued securities.

Sincerely,

Cecelia B. Moore

Cecelia Moore
Associate Vice Chancellor for Finance
Vanderbilt University Medical Center

3319 West End Avenue
Suite 700
Nashville, TN 37203-6840

tel 615.322.0084
www.finance.vanderbilt.edu

Attachment C.Economic Feasibility.10

Vanderbilt University Medical Center Financial Statements

2013

2013 FINANCIAL REPORT

VANDERBILT UNIVERSITY

Contents

Letter from the Chancellor

Vanderbilt University continues to excel in a very challenging environment. We remain focused on our core mission and set our priorities with a keen eye on the important role that Vanderbilt plays in society. Educating amazing students with enormous potential, pursuing breakthroughs in research across the entire range of disciplinary inquiry, and providing new and more effective ways to prevent and treat disease determine how we invest in our people and infrastructure.

Vanderbilt's impact and visibility reached new heights in the past year. Yet it did so despite the ever-challenging fiscal and economic environment in which the great research universities operate. The blunt and short-sighted cuts in research and Medicare through sequestration demanded prudence on both the operating and capital sides. Health care is undergoing rapid transformations, buffeted by market adaptations and political decisions at all levels of government. More than ever, quality and efficiency are driving not simply the rhetoric but the actions of payers and providers. Vanderbilt, with its focus on innovation, excellence in care, and quality outcomes is positioned well to thrive in this new health care world.

Long-term stewardship remains the lodestar for managing our finances and meeting our mission. While this perspective is increasingly rare in our society, we feel fortunate to be able to manage through short-term disruptions knowing that our responsibilities are inter-generational. This past year has been a strong one, for the many successes but also for maintaining our strong foundation for the future.

Sincerely,

Nicholas S. Zeppos
Chancellor

Vanderbilt University Statistics

	2012/2013	2011/2012	2010/2011	2009/2010	2008/2009
STUDENTS					
Undergraduate	6,796	6,817	6,879	6,794	6,637
Graduate and professional	5,914	6,019	5,835	5,712	5,455
Total fall enrollment	12,710	12,836	12,714	12,506	12,092
Undergraduate admissions					
Applied	28,348	24,837	21,811	19,353	16,944
Accepted	4,034	4,078	3,914	3,899	4,292
Enrolled	1,608	1,601	1,600	1,599	1,569
Selectivity	14.2%	16.4%	17.9%	20.1%	25.3%
Yield	39.9%	39.3%	40.9%	41.0%	36.6%
Degrees conferred					
Baccalaureate	1,675	1,673	1,735	1,583	1,568
Master's	1,421	1,432	1,252	1,280	1,235
M.D.	111	99	97	118	103
Other doctoral	551	516	556	515	477
Total degrees conferred	3,758	3,720	3,640	3,496	3,383
Undergraduate six-year graduation rate	92.5%	92.2%	91.9%	90.6%	90.7%
Undergraduate tuition	$ 41,088	$ 40,320	$ 38,952	$ 37,632	$ 36,100
% increase over prior year	1.9%	3.5%	3.5%	4.2%	4.9%
HOSPITALS AND CLINICS					
Licensed beds	1,019	985	916	916	836
Inpatient days	307,292	285,270	282,547	272,731	265,733
Discharges	57,768	53,818	52,453	51,874	51,575
Average daily census	842	782	774	747	728
Average length of stay (days)	5.3	5.3	5.4	5.3	5.2
Average occupancy level	83.3%	83.6%	84.5%	83.6%	87.1%
Hospital surgical operations - inpatient	22,396	22,183	22,246	21,702	21,283
Hospital surgical operations - outpatient	30,023	28,815	25,650	23,790	18,597
Ambulatory visits	1,833,337	1,725,901	1,586,395	1,450,196	1,266,255
Emergency visits	119,225	114,051	109,987	108,398	102,631
LifeFlight (helicopter) missions	2,359	2,550	2,203	2,152	2,112
Case mix index	1.93	1.90	1.93	1.93	1.89
FACULTY AND STAFF					
Full-time faculty	3,672	3,551	3,448	3,309	3,131
Full-time staff	20,160	20,119	19,192	18,089	17,160
Part-time faculty	430	439	396	424	402
Part-time staff	764	768	798	683	676
Total headcount	25,026	24,877	23,834	22,505	21,369
RESEARCH EXPENDITURES FUNDING (in thousands)					
Federal grants and contracts	$ 312,312	$ 310,786	$ 320,211	$ 279,282	$ 250,431
Nonfederal grants, contracts, and other	62,982	57,625	54,694	57,880	64,061
Facilities and administrative costs recovery	137,719	142,663	140,205	125,526	114,509
Institutional resources, including cost sharing	58,329	48,042	47,959	48,115	45,990
Total research expenditures	$ 571,342	$ 559,116	$ 563,069	$ 510,803	$ 474,991
ENDOWMENT					
Market value (in thousands)	$ 3,635,343	$ 3,360,036	$ 3,375,153	$ 3,007,607	$ 2,833,614
Endowment return	9.3%	1.3%	13.6%	8.9%	-16.3%
Endowment per student	$ 286,022	$ 261,767	$ 265,467	$ 240,493	$ 234,338
Endowment payout (spending formula)	4.3%	4.4%	4.8%	5.2%	4.7%
Endowment payout (strategic initiatives)	-	-	-	0.1%	0.1%
Total endowment payout	4.3%	4.4%	4.8%	5.3%	4.8%

Financial Overview

Vanderbilt manages its operations with a focus on achieving long-term financial equilibrium. In an unpredictable external environment with such challenges as uncertain research funding levels, concerns about rising health care costs, and the impact of market changes, Vanderbilt remains steadfast in setting priorities in an effort to excel at research, discovery, service, and education for generations to come. Fiscal 2013 was a challenging year that produced sound financial results.

The university's total net assets grew $320 million in fiscal 2013, compared to a decrease of $71 million in fiscal 2012, as positive investment returns were experienced and LIBOR rates improved, positively impacting the value of interest rate exchange agreements. The university's change in unrestricted net assets from operating activities in fiscal 2013 was negative $44 million, a decrease from $158 million in fiscal 2012. This decrease primarily was related to a change in the balance sheet estimate of the net realizable value of patient receivables.

The demand for a Vanderbilt education remains strong. The number of applications received for both undergraduate and professional schools achieved new records. Undergraduate applications for the fall of 2012 grew 14.1% to a total of 28,348 with a selectivity rate of 14.2%, compared to 16.4% for the fall of 2011—and the fall of 2013 selectivity rate was at a record 12.7% level.

Vanderbilt remains committed to ensuring that young people of every background can attend the university, creating a dynamic learning community that benefits every student. Vanderbilt's decision to replace need-based loans with scholarship support through Opportunity Vanderbilt (OV) gives talented undergraduates opportunities to consider career choices and educational dreams without the prospect of significant debt.

Vanderbilt continues to lead in research. Faculty recruiting and retention remain vibrant, enhancing the overall educational experience for all Vanderbilt students. Fundraising continues to grow and expand in support of Vanderbilt's long-term priorities.

Despite current environmental challenges, Vanderbilt is positioned to remain a distinguished research institution with world-class faculty and staff, topnotch students, and outstanding health care services. While the university is well-positioned to sustain excellence and take advantage of future opportunities, it is important to remain keenly aware of the challenges ahead.

Financial Position

As of June 30, 2013, Vanderbilt's financial position consisted of assets totaling $7,606 million and liabilities totaling $2,267 million, resulting in net assets of $5,339 million.

Summary of Financial Position
as of June 30, in millions

	2013	2012
ASSETS		
Working capital cash and investments	$ 1,120	$ 1,210
Endowment and other cash and investments	4,054	3,776
Accounts and contributions receivable	565	675
Property, plant, and equipment, net	1,781	1,728
Prepaid expenses and other assets	86	82
Total assets	**$ 7,606**	**$ 7,471**
LIABILITIES		
Payables and accrued liabilities	$ 626	$ 636
Deferred revenue	93	119
Interest rate exchange agreements	207	316
Taxable debt for liquidity	250	250
Project and equipment-related debt	1,091	1,131
Total liabilities	**2,267**	**2,452**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt University	2,785	2,560
Unrestricted net assets related to non-controlling interests	187	201
Temporarily restricted net assets	1,235	1,191
Permanently restricted net assets	1,132	1,067
Total net assets	**5,339**	**5,019**
Total liabilities and net assets	**$ 7,606**	**$ 7,471**

Total net assets include Vanderbilt's endowment valued at $3,635 million as of June 30, 2013. Net assets associated with capital infrastructure totaled $690 million, which represents the university's property, plant, and equipment, net of accumulated depreciation and capital-related debt. Other net assets, which totaled $1,014 million as of June 30, 2013, include current assets and current liabilities, net of mark-to-market adjustments on interest rate exchange agreements, and net assets related to noncontrolling interests.

Vanderbilt's assets, totaling $7,606 million as of June 30, 2013, reflect a 1.8% increase from the prior year. This increase primarily is attributable to increases in the endowment.

Total liabilities decreased by $185 million to $2,267 million as of June 30, 2013. This decrease is attributable largely to a decrease in the mark-to-market liability associated with the university's interest rate exchange agreements.

The summary of financial position shown on this page summarizes several asset and liability lines from the consolidated statements of financial position. The summary on this page also segregates the university's cash and investments into: (a) working capital, which consists of operating accounts and proceeds from taxable liquidity borrowings, and (b) endowment and other cash and investments. The summary segregates debt between taxable debt designated for liquidity enhancement and capital-related debt.

Cash and Liquidity

Vanderbilt's working capital cash and investments, which include highly liquid operating accounts, amounts posted as collateral (primarily related to interest rate exchange agreements), and amounts invested in the long-term investment pool alongside the endowment, totaled $1,120 million as of June 30, 2013.

Operating assets continue to be invested in a conservative, diversified manner to ensure adequate liquidity under modeled stress scenarios. During the past year Vanderbilt's endowment also provided increased liquidity support, especially monthly liquidity, while still maintaining a long-term investment horizon. As of June 30, 2013, $1,865 million of operating and endowment assets were available within 30 days, including $726 million available on a same-day basis. Based largely on this very strong liquidity position, Vanderbilt maintains the highest short-term ratings from the major credit rating agencies.

To provide supplemental liquidity support, Vanderbilt maintains an agreement with one bank to provide a general operating line of credit with a maximum available commitment totaling $100 million. In addition, Vanderbilt carries $400 million of revolving credit facilities with two additional banks to provide dedicated self-liquidity support for the debt portfolio; one of these lines, totaling $200 million, includes a general use provision.

Debt

Vanderbilt's debt portfolio includes fixed-rate debt, variable-rate debt, and commercial paper, along with interest rate exchange agreements that are used for hedging interest rate exposure within the university's debt portfolio.

In accordance with our strategic capital plan, Vanderbilt did not issue incremental debt during fiscal 2013. Scheduled principal payments on long-term debt reduced total outstanding debt by $40 million to a balance of $1,341 million as of June 30, 2013. This amount consisted of $1,091 million of capital project-related debt and $250 million of taxable debt for liquidity support.

During fiscal 2013, Vanderbilt refinanced $120 million of weekly-remarketed variable-rate debt with fixed-rate bonds having a maturity of 25 years, which eliminated weekly remarketing risk. Also, to further reduce remarketing risk, Vanderbilt refinanced $50 million of tax-exempt commercial paper with fixed-rate notes having a maturity of seven years.

Statements of Activities

Vanderbilt's total operating and nonoperating activity resulted in a $320 million increase in net assets in fiscal 2013, which follows a $71 million decrease in fiscal 2012.

Summary of Statements of Activities
all net asset categories, in millions

	2013	2012
CONSOLIDATED REVENUES		
Tuition and educational fees, net of financial aid	$ 266	$ 250
Government grants and contracts and F&A costs recovery	520	545
Private grants and contracts	62	55
Contributions	111	83
Endowment distributions	151	148
Investment income	22	19
Health care services	2,394	2,462
Room, board, and other auxiliary services, net of financial aid	113	110
Other sources	53	39
Total consolidated revenues	**3,692**	**3,711**
CONSOLIDATED EXPENSES		
Instruction, academic support, and student services	689	658
Research	447	435
Health care services	2,326	2,221
Public service	34	46
Institutional support	52	38
Room, board, and other auxiliary services	121	109
Total consolidated expenses	**3,669**	**3,507**
OTHER CHANGES IN NET ASSETS		
Changes in appreciation of endowment, net of distributions	169	(95)
Gains (losses) on interest rate exchange agreements	109	(181)
(Decrease) increase in net assets related to noncontrolling interests	(14)	2
Other nonoperating activity	33	(1)
Total other changes in net assets	**297**	**(275)**
Increase (decrease) in net assets	**$ 320**	**$ (71)**

During fiscal 2013, the increase in total net assets primarily resulted from strong endowment investment returns and mark-to-market gains on interest rate exchange agreements. In comparison, the decrease in fiscal 2012 primarily resulted from strong net operating activity offset by mark-to-market losses on interest rate exchange agreements and an excess of endowment distributions over investment return.

Consolidated revenues and expenses, as presented on this page, include revenues and other support in all net asset categories. Operating activity specific to *unrestricted* net assets is discussed in the unrestricted operating activity section. In addition to unrestricted operating activity, consolidated revenues include activity in *temporarily restricted* and *permanently restricted* net assets.

Consolidated Revenues

Consolidated revenues decreased $19 million or 0.5% to $3,692 million in fiscal 2013, as compared to $3,711 million in fiscal 2012. This decrease was driven primarily by a $68 million, or 2.8%, decrease in health care services revenue largely due to a change in balance sheet estimate of the net realizable value of patient receiva-

bles during fiscal 2013. Vanderbilt's health care services are discussed further in a subsequent section.

Vanderbilt remains firmly committed to student access and affordability. To facilitate this, the university provides significant financial aid to students and their families. In fiscal 2013, Vanderbilt provided $239 million in aid support to its students for tuition and room and board, as shown in the table below.

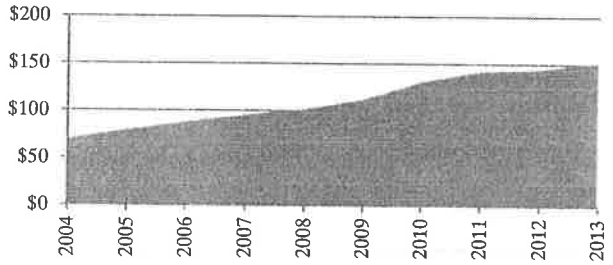
Tuition, Room and Board (R&B) and Financial Aid
fiscal 2013, in millions

	Gross tuition and fees and R&B	Financial aid[1]	Net tuition and fees and R&B
Undergraduate (6,796 students)	$ 358	$ 153	$ 205
Graduate and Professional (5,914 students)	183	86	97
Total	**$ 541**	**$ 239**	**$ 302**

[1] The financial aid number above excludes Pell Grants of $4 million. Pell Grants are considered agency funds and are excluded from the GAAP financial statements.

Over the past decade, Vanderbilt has more than doubled its level of support for undergraduate aid, as shown in the graph below.

Undergraduate Financial Aid
fiscal 2004 - 2013, $ million



For undergraduates, aid as a percentage of gross tuition, room and board, and educational fees in fiscal 2013 was 43%. That aid is funded in part by endowments, gifts and external agencies. Critical to this support is the university's OV fundraising initiative begun in fiscal 2009 to support undergraduate financial aid. As of June 30, 2013, that initiative had raised $154 million.

Contributions revenue within the consolidated financial statements is calculated based on Generally Accepted Accounting Principles (GAAP). This is a different basis for measurement than reported using guidelines established by the Council for Advancement and Support of Education (CASE). CASE guidelines represent the development reporting standard for colleges and universities and focus on philanthropic distributions of private resources to benefit the public.

On a GAAP-basis, in fiscal 2013, Vanderbilt recorded $116 million in contributions revenue, including pledges, a 34% increase over the $85 million in fiscal 2012. A reconciliation of the CASE and GAAP totals is provided below:

GAAP to CASE Reconciliation
in millions

	2013
Total consolidated GAAP contributions	$ 116
Grants and similar agreements meeting CASE guidelines (gifts per CASE standards)	29
Decrease in net contributions receivable (fiscal 2012 to 2013)	2
CASE reported gifts (cash basis)	**$ 147**

Consolidated Expenses

Consolidated expenses increased 4.6% to $3,669 million in fiscal 2013, as compared to $3,507 million in fiscal 2012. This increase was driven primarily by a 4.7% increase in health care services expenses, and a 4.7% increase in total instruction, academic support, and student services expenses.

Other Changes in Net Assets

Other changes in net assets included changes in appreciation of endowment, net of distributions, totaling $169 million in fiscal 2013 and negative $95 million in fiscal 2012. The fiscal 2013 change in appreciation for the endowment resulted from a 9.3% investment return offset by 4.3% of the endowment utilized for distributions.

In fiscal 2013, Vanderbilt incurred net unrealized gains totaling $109 million on interest rate exchange agreements. These gains are based on mark-to-market valuations of the university's portfolio of interest rate exchange agreements, especially fixed-payor exchange contracts. Adjustments to annual interest expense occur for net cash settlements as Vanderbilt *pays* an average of 3.8% on its fixed-payor contracts and *receives* amounts based on a percentage of 1-month LIBOR rates. The unrealized mark-to-market valuation on these agreements was driven primarily by long-term LIBOR rates. During the past year, the 30-year LIBOR rate increased to 3.5% as of June 30, 2013—up from 2.5% as of June 30, 2012—which resulted in a decrease to the fair value of the liability for the agreements.

Net assets related to noncontrolling interests decreased $14 million due to the change in appreciation allocable to noncontrolling interests combined with a planned write-down of assets related to the contractual obligations set forth in the partnership agreement. Finally, net other nonoperating activity totaled $33 million in fiscal 2013 compared to negative $1 million in fiscal 2012. This increase primarily was the result of net gains on working capital invested alongside the endowment and other nonoperating investments.

Summary of Changes in Net Assets
in millions

	2013	2012
Revenues and expenses:		
Unrestricted operating revenues	$ 3,625	$ 3,665
Unrestricted operating expenses	(3,669)	(3,507)
Unrestricted operating activity	(44)	158
Contribution activity in temporarily restricted and permanently restricted net assets	59	36
Investment income and endowment distributions in temporarily restricted and permanently restricted net assets	8	10
Other changes in net assets:		
Change in appreciation of endowment, net of distributions	169	(95)
(Gains) losses on interest rate exchange agreements	109	(181)
(Decrease) increase in net assets related to non-controlling interests	(14)	2
Other nonoperating activity	33	(1)
Increase (decrease) in net assets	**$ 320**	**$ (71)**
Ending balance of net assets	**$ 5,339**	**$ 5,019**

Unrestricted Operating Activity

The change in unrestricted net assets from operating activity is the measure of the university's *operating results*. This unrestricted operating activity totaled negative $44 million in fiscal 2013 and $158 million in fiscal 2012.

Operating Revenues

Unrestricted operating revenues totaled $3,625 million in fiscal 2013, reflecting a 1.1% decrease from the prior year.

Operating Revenues by Source
unrestricted net assets, in millions

	2013	2012
Tuition and educational fees, net of financial aid	$ 266	$ 250
Government grants and contracts	378	397
Private grants and contracts	62	55
F&A costs recovery	142	148
Contributions, including net assets released from restrictions	52	47
Endowment distributions	145	137
Investment income	20	20
Health care services	2,394	2,462
Room, board, and other auxiliary services, net of financial aid	113	110
Other sources	53	39
Total operating revenues	**$ 3,625**	**$ 3,665**

Due largely to governmental budgetary constraints, government and private grants and contracts revenue, predominantly for research activities, and facilities and administrative (F&A) costs recovery declined 2.7% from fiscal 2012 to 2013 (from $452 million to $440 million). Within the pool of direct grant revenues, while government grants and contracts declined by 4.8% from fiscal 2012 to 2013 (from $397 million to $378 million), private grants and contracts direct revenues increased 12.7% over the same time period (from $55 million to $62 million).

As shown in the table below, the largest portion of the $440 million in total direct grant and contract revenue for fiscal 2013 was funded by the Department of Health and Human Services. Other external sources include state and local governments, industry, foundations, and private sources.

Grants and Contracts Revenues by Funding Source
in millions

	2013	%
Dept. of Health and Human Services	$ 294	67%
Dept. of Defense	28	6%
Associations and foundations	26	6%
Corporations	25	6%
Dept. of Education	22	5%
National Science Foundation	17	4%
Other government and private agencies	28	6%
Total sponsored research and project awards	**$ 440**	**100%**

Sponsored research and project awards (awards represent research funding commitments that have not yet been expended by Vanderbilt), which include multiple-year grants and contracts from government sources, foundations, associations, and corporations, totaled $616 million in fiscal 2013 and $571 million in fiscal 2012.

Sponsored Research and Project Awards
in millions

	2013	2012
Government awards	$ 477	$ 456
Non-government awards	139	115
Total sponsored research and project awards	**$ 616**	**$ 571**

Federal and state awards accounted for approximately 77% of the total sponsored funding during fiscal 2013 and increased to $477 million, or 5%, in fiscal 2013 from $456 million in fiscal 2012. Non-federal awards increased to $139 million, or 21%, in fiscal 2013 from $115 million in fiscal 2012. The growth in federal

awards is particularly impressive given the pressures on federal funding, while growth in non-federal awards signals Vanderbilt's continued success in diversifying its research award pipeline.

Operating Expenses

Operating expenses totaled $3,669 million in fiscal 2013, reflecting a 4.6% increase from the prior year.

Operating Expenses by Function

unrestricted net assets, in millions

	2013	2012
Instruction, academic support, and student services	$ 689	$ 658
Research	447	435
Health care services	2,326	2,221
Public service	34	46
Institutional support	52	38
Room, board, and other auxiliary services	121	109
Total operating expenses	**$ 3,669**	**$ 3,507**

Expenses for instruction, academic support, and student services increased $31 million, or 4.7%, in fiscal 2013. These expenses substantially exceed net tuition revenues, which are noted in the operating revenues by source table. Vanderbilt, like other major private research universities, relies upon contributions, endowment support, and other alternative sources of revenue—in addition to tuition—to meet its educational mission objectives. Research expenses increased $12 million, or 2.8%, to $447 million in fiscal 2013 from $435 million in fiscal 2012.

Health care services expenses increased $105 million, or 4.7%, to $2,326 million in fiscal 2013 from $2,221 million in fiscal 2012. This increase is attributable largely to an overall increase in patient volumes. Inpatient volumes increased 7.7% and outpatient volumes increased 6.2% from fiscal 2012 to fiscal 2013. Vanderbilt's health care services are discussed further in the next section.

Health Care

Health care is an industry that is poised to change dramatically in years to come with the full implementation of the 2010 Patient Protection and Affordable Care Act, occurring in 2014. Collaboration with other health care providers is a key success factor in this new environment. In fiscal 2013, Vanderbilt University Medical Center (VUMC) launched the Vanderbilt Health Affiliated Network (VHAN), one of the largest clinically integrated networks of doctors, regional health systems, and other health care providers in Tennessee and surrounding states. In the VHAN clinically integrated network, academic medical centers, community hospitals, physicians, insurers, and ancillary health service providers remain independent but affiliated to actively collaborate to provide patients with high-quality, efficiently coordinated, and cost—effective health care services. As a result of these affiliations, VUMC and its affiliated medical centers have created a new health plan of clinicians and hospitals which will allow employees the opportunity to receive health care at any of the participating affiliated medical centers or through participating providers in the community. During fiscal 2013, VHAN was offered as an alternative health plan administered by Aetna to Vanderbilt employees. As of June 30, 2013, the VHAN participating affiliates included 14 hospitals and 3,000 providers.

In fiscal 2013, the Centers for Medicare and Medicaid Services (CMS) awarded VUMC a three-year $18.8 million grant to improve chronic disease management for patients with high blood pressure, heart failure, and diabetes. This Health Care Innovation Award is one of the largest federal research grants awarded to VUMC investigators. VUMC is joined in this grant by several of the VHAN affiliated hospitals.

Like many of its peers, Vanderbilt is also responding to the pressure of flat revenue streams by focusing on efficiency in patient care processes to reduce costs and improve outcomes. Strategies include developing flexible staffing models to more efficiently staff to demand, standardizing clinical operations to reduce costs and improve quality, supply chain standardization, and reductions in administrative overhead costs.

VUMC finished fiscal 2013 in the *U.S. News & World Report* annual ranking of America's Best Hospitals with 11 ranked specialties out of a possible 16 categories. Specialty programs ranking among the top 50 in their respective fields: cancer; cardiology and heart surgery; ear, nose, and throat; gastroenterology; geriatrics; gynecology; nephrology; neurology and neurosurgery; orthopedics; pulmonology; and urology. Vanderbilt was among only 3% of 4,806 facilities analyzed for this year's rankings to be named in at least one specialty. In addition, the Monroe Carell Jr. Children's Hospital at Vanderbilt was included among the nation's leaders in pediatric health care in *U.S. News & World Report* magazine's Best Children's Hospital rankings. The hospital achieved rankings in nine out of 10 specialties: cancer; cardiology and heart surgery; diabetes and endocrinology; gastroenterology; neonatology; neurology and neurosurgery; orthopedics; pulmonology; and urology.

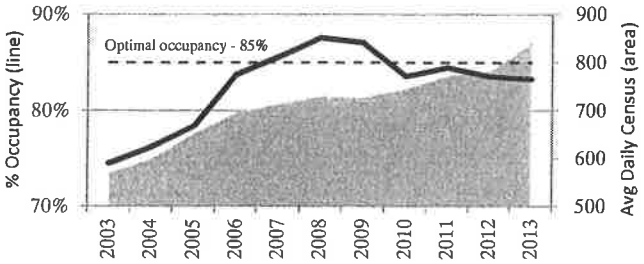
VUMC has been granted Magnet® status by the American Nurses Credentialing Center's Magnet Recognition Program®. The Magnet Recognition Program® recognizes organizations for quality patient care, nursing excellence and innovations in professional nursing practice. In addition, Vanderbilt University Hospital received an "A" for its Hospital Safety Score from the Leapfrog Group, a coalition of public and private purchasers of employee health coverage aiming to promote health care safety, quality, and affordability. The Leapfrog Group surveyed about 2,500 hospitals, awarding them scores of A, B, C, D, or F.

Successful volume growth in recent years led to peaking occupancy rates and capacity constraints in Vanderbilt's hospitals. Vanderbilt's overall hospital occupancy rates were 83.3% in fiscal 2013, an anticipated slight decrease from 83.6% in fiscal 2012, due to the addition of 34 licensed beds during fiscal 2013.

Vanderbilt completed construction of the 10th floor of the Critical Care Tower in November 2012 resulting in the addition of 34 beds. The 5th floor of the Critical Care Tower is currently under construction as a procedural area for Vanderbilt Heart Institute. The relocation of services to the Critical Care Tower will enable the addition of 12 beds in adjacent areas by the end of calendar 2013. The bed expansions are necessary to manage occupancy approaching the 85% range and to avoid overcrowding and long wait times for pa-

tients in the emergency room, recovery rooms, and other procedural staging areas.

Percentage Occupancy and Average Daily Census



Inpatient hospital surgical operations increased 1.0% in fiscal year 2013 compared to the prior year while surgeries for outpatients increased 4.2%. In the outpatient clinics, ambulatory visits increased 6.2% to a total 1,833,337 in fiscal 2013 as Vanderbilt continued its expansion of health care services offered outside the medical center's main campus. Approximately 45% of outpatient visits occurred at off-campus locations. Growth in ambulatory visits also occurred as the result of physician practice expansions in obstetrics and gynecology and pediatrics in nearby Williamson and Wilson counties.

The average length of stay for patients in Vanderbilt's hospitals remained consistently low at 5.3 days in fiscal 2013, the same length of stay as in fiscal 2012.

The medical center's overall case mix index (CMI) increased to 1.93 in fiscal 2013 from 1.90 in fiscal 2012, due to significant growth in surgical CMI, primarily within Vanderbilt Heart Institute. The surgical case mix index was 3.46 in fiscal 2013 as compared to 3.28 in fiscal 2012.

The following table shows payor mix percentages based on gross patient revenues for Vanderbilt's hospitals and clinics in fiscal 2013 and fiscal 2008 (five years prior). The increase in Medicare patients is due to aging population demographics and is consistent with Medicare growth of other hospital systems in Middle Tennessee. The patient increase in Tenncare/Medicaid is driven by high growth in obstetrics and pediatric services, which have a higher Tenncare/Medicaid payor mix than other service lines.

Payor Mix

Vanderbilt hospitals and clinics (% of gross patient revenues)

	2013	2008
Commercial/Managed Care	45.5%	47.9%
Medicare/Managed Medicare	28.8	26.8
TennCare/Medicaid	19.4	18.8
Uninsured (self-pay)	6.3	6.5
Total payor mix	**100.0%**	**100.0%**

Vanderbilt remains committed to providing high quality health care services that meet key community needs, including providing substantial charity care for members of the community who otherwise would not be able to secure needed services.

VUMC maintains a charity care policy which sets forth the criteria for health care services that are provided without expectation of payment, or at a reduced payment rate to patients who meet certain income criteria based on federal poverty limit guidelines. These services are accounted for as charity care and are not reported as revenue. Charity care services, at established charges, represent 5.3% of total patient services revenue in fiscal 2013 and 2012, respectively.

The total cost of uncompensated care (comprising charity care and bad debt) was $137.8 million and $134.3 million for fiscal 2013 and 2012, respectively. Of the total uncompensated care, charity care represented 85.3% and 84.8% in fiscal 2013 and 2012, respectively.

Charity Care and Bad Debt Costs

in millions

	2013	2012
Unreimbursed charity care cost	$ 117,614	$ 113,833
Unreimbursed bad debt cost	20,212	20,429
Total uncompensated care	**$ 137,826**	**$ 134,262**
Charity care as % of total uncompensated care	*85.3%*	*84.8%*

In addition to uncompensated care, the medical center provides a number of other services to benefit the economically disadvantaged for which little or no payment is received. These services include public health education and training for new health professionals and services to patients with special needs. Vanderbilt also provides other substantial community benefits in the form of clinical and laboratory research support. This activity primarily is conducted by the schools of medicine and nursing and includes direct and indirect costs of research funded by other organizations, government entities, and internal funding sources.

A summary of costs for the community benefit activities, which are regularly reported in Vanderbilt's Form 990 filing (Return of Organization Exempt from Income Taxes), is provided in the following table.

Charity Care Assistance, Community Benefits, and Other Unrecovered Costs

in millions

	2013	2012
Charity care and community benefits		
Unreimbursed charity care cost	$ 117,614	$ 113,833
Resident and Allied Health education	89,130	82,552
Unreimbursed cost of TennCare/ Medicaid	60,902	47,213
Other community health programs	5,678	5,386
Behavioral health hospital services	-	806
Clinical and laboratory research support	496,201	515,018
Total costs of charity care and community benefits	769,525	764,808
Other unrecovered costs using IRS Form 990 Schedule H guidelines but not includable as community benefits		
Unreimbursed cost of Medicare	50,030	54,662
Unreimbursed bad debt costs	20,212	20,429
Unreimbursed cost of TRICARE	3,792	8,701
Total other unrecovered costs	74,034	83,792
Total cost of charity care, community benefits, and other unrecovered costs	**$ 843,559**	**$ 848,600**

In the preceding table, clinical and laboratory expense of $496 million includes sponsored research, primarily from the National Institutes of Health (NIH), as well as other federal and non-federal agencies, for the support of basic and clinical research. In addition,

institutional funds are included to provide support for unfunded research such as bridge funds for faculty between grant periods, and for new ideas or new science that may receive funding in future years.

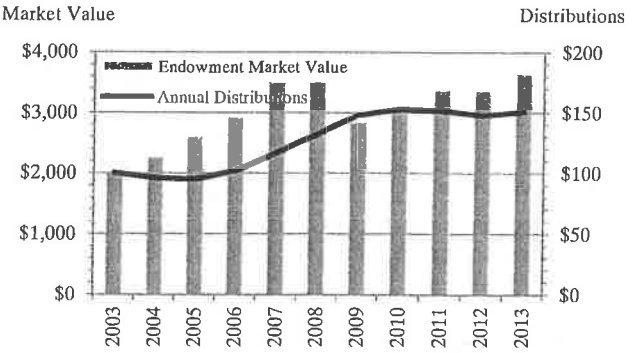
Endowment

For fiscal 2013, Vanderbilt's endowment portfolio returned 9.3%. The endowment ended fiscal 2013 with a $3,635 million total market value compared to $3,360 million in fiscal 2012. The difference between the investment return and change in absolute value of the endowment reflects the net impact of new endowment gifts, additions to institutional endowments (quasi-endowments), investment returns, costs for managing the endowment, and the distribution of endowment funds to support university operations. During fiscal 2013, the university added $117 million to the endowment portfolio through new gifts and additions to institutional endowments (quasi-endowments). Endowment distributions totaled $151 million in fiscal 2013, compared to $148 million in fiscal 2012. These distributions were used to support the university's education, research, and public service missions.

The last 12 months saw a continuation of the equity bull market that began in March 2009 on the back of unprecedented accommodative monetary policies by central banks across the world, particularly the U.S. Federal Reserve. Global equity markets rallied 17%, with the United States, Japan, and Europe excluding UK each posting returns greater than 20% and significantly outperforming the so-called BRICs (Brazil, Russia, India, and China) which collectively posted another lackluster year. Treasuries struggled with the long end of the yield curve declining almost -9% while gold and silver both lost their shine, declining –27% and –36%, respectively.

Vanderbilt's endowment benefited from the market rally as most asset classes posted positive returns. As we look to the future, we believe there are multiple headwinds still ahead—U.S. unemployment remains stubbornly high, the fiscal crisis in Europe still looms large, emerging markets continue to face increased inflationary pressures and sluggish growth, and there does not seem to be an end in sight to the multiple geopolitical crises confronting the world. In addition, conversations about when the U.S. Federal Reserve will end its asset buying program continue to drive recent market volatility. That said, we believe these challenges will present great opportunities as we lay the foundation for a resilient portfolio by focusing on strong risk management and partnering with best-in-class investment managers across the globe.

Endowment Market Value and Annual Distributions
in millions



Endowment Asset Allocation
June 2013 (% of portfolio)

	Actual	Target
Global equities	28.1%	35.0%
Absolute return	22.8	25.0
Fixed income	5.1	10.0
Cash and cash equivalents	0.4	-
Total marketable	**56.4**	**70.0**
Private markets	28.3	15.0
Real estate	6.7	7.5
Natural resources	8.6	7.5
Total nonmarketable	**43.6**	**30.0**
Total endowment	**100.0%**	**100.0%**

Conclusion

Although the economy still holds its challenges for the future, especially related to uncertainty surrounding government funding and health care reform, we continue to stay focused on operating effectively and efficiently to protect Vanderbilt's financial health and provide resources to areas of high importance to continue to fulfill our mission and serve the community.

Vanderbilt ended fiscal 2013 in a strong financial position with $5.3 billion in net assets. This is a strong platform to build upon to sustain our excellence. Vanderbilt's audited financial statements, financial ratios, and other key financial metrics are included in the pages that follow.

Financial Ratios

Expendable Net Assets to Debt

Expendable Net Assets / Project Debt and Lease Commitments

2009	2010	2011	2012	2013
1.9x	2.1x	2.3x	2.4x	2.7x

Expendable net assets to debt measures the university's leverage. Debt used for calculating this ratio consists of all project-related debt, the net present value of lease commitments, and debt guarantees.

Vanderbilt's expendable net assets to debt increased in fiscal 2013 as the result of a net increase in endowment market value, a decrease in interest rate exchange agreements portfolio liability, and a decline in outstanding debt, tempered by a net operating loss. The improvement in fiscal 2012 was the result of positive operating results and a decline in outstanding debt, tempered by a net decrease in endowment market value and an increase in interest rate exchange agreements portfolio liability. Vanderbilt aims to maintain expendable net assets to debt of at least 2.0.

Debt Service Coverage Ratio

Unrestricted Operating Results before Interest and Depreciation / Normalized Annual Debt Service

2009	2010	2011	2012	2013
3.2x	3.6x	4.0x	4.1x	2.1x

The *debt service coverage ratio* measures the university's ability to pay annual debt service obligations from current year operating activities. In this context, annual debt service is normalized to calculate long-term (25 years), level principal and interest payments that would be required based on the portfolio's then-prevailing weighted average interest rates inclusive of the effects of interest rate exchange agreements. The scope for this ratio is all outstanding debt, except for taxable commercial paper used for short-term liquidity support prior to fiscal 2012.

Vanderbilt's debt service coverage ratio decreased in fiscal 2013 as the result of a decrease in operating results tempered by a slight decrease in normalized debt service. Although the debt portfolio's effective interest rate, which includes the impact of interest rate exchange agreements, increased slightly in fiscal 2013, average outstanding debt decreased in fiscal 2013 resulting in a favorable impact on normalized annual debt service. The improvement in fiscal 2012 was primarily the result of positive operating results. Vanderbilt aims to maintain a debt service coverage ratio of at least 2.0.

Debt Service Burden

Normalized Annual Debt Service / Unrestricted Operating Expenses

2009	2010	2011	2012	2013
2.7%	3.3%	2.9%	2.8%	2.6%

The *debt service burden* measures the percent of the annual operating budget devoted to servicing outstanding debt.

Vanderbilt's debt service burden decreased in fiscal 2013 and 2012 primarily due to an increase in operating expenses. Normalized debt service decreased slightly in fiscal 2013. Vanderbilt aims to maintain a debt service burden below 5.0%.

Operating Cash Flow Margin

Unrestricted Operating Results before Interest and Depreciation / Unrestricted Operating Revenues

2009	2010	2011	2012	2013
8.7%	11.4%	11.1%	10.9%	5.5%

The *operating cash flow margin* measures the cash flow generated from each dollar of operating revenue. The resulting net cash flows may occur in the current or future years depending on changes in receivables and payables.

In fiscal 2013, Vanderbilt's unrestricted operating results before interest and depreciation decreased 50.0% to $199 million from $398 million in fiscal 2012. Fiscal 2013 unrestricted operating revenues, at $3,625 million, represent a 1.1% decrease from $3,665 million in fiscal 2012.

Capital Intensiveness Ratio

Acquisitions of Property, Plant, and Equipment / Unrestricted Operating Revenues

2009	2010	2011	2012	2013
8.5%	5.2%	3.6%	3.9%	6.2%

The *capital intensiveness ratio* measures the university's annual investments in property, plant, and equipment as a percentage of the university's annual operating revenues.

Vanderbilt's capital intensiveness ratio increased in fiscal 2013 as spending on major capital projects increased in accordance with the university's capital plan.

Average Age of Plant

Accumulated Depreciation / Depreciation Expense

2009	2010	2011	2012	2013
9.5 yrs	10.0 yrs	10.2 yrs	11.2 yrs	11.8 yrs

The *average age of plant* metric provides a sense of the age of the university's facilities. A low average age of plant indicates that an institution has made significant recent investments in its plant.

During fiscal 2013, Vanderbilt's spending on major capital projects increased in accordance with the university's capital plan; however, construction was still in progress for the Critical Care Tower Phase 2, College Halls at Kissam, and Alumni Hall renovation as of June 30, 2013.

VANDERBILT UNIVERSITY

Consolidated Financial Statements

pwc

Independent Auditor's Report
Board of Trust
Vanderbilt University

We have audited the accompanying consolidated financial statements of Vanderbilt University (the "University"), which comprise the consolidated statement of financial position as of June 30, 2013 and June 30, 2012, and the related consolidated statements of activities and changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the University's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the University's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Vanderbilt University at June 30, 2013 and June 30, 2012, and the changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

October 18, 2013

PricewaterhouseCoopers LLP, PricewaterhouseCoopers Center, 300 Madison Avenue, New York, NY 10017
T: (646) 471 3000, F: (813) 236 6000, www.pwc.com/us

Vanderbilt University
Consolidated Statements of Financial Position

As of June 30, 2013 and 2012 (in thousands)

	2013	2012
ASSETS		
Cash and cash equivalents	$ 845,472	$ 912,419
Accounts receivable, net	413,172	518,566
Prepaid expenses and other assets	85,675	82,167
Contributions receivable, net	70,302	72,334
Student loans and other notes receivable, net	43,582	45,409
Investments	4,141,408	3,872,014
Investments allocable to noncontrolling interests	186,901	201,386
Property, plant, and equipment, net	1,781,293	1,727,611
Interests in trusts held by others	38,091	39,257
Total assets	**$ 7,605,896**	**$ 7,471,163**
LIABILITIES		
Accounts payable and accrued liabilities	$ 226,643	$ 228,422
Accrued compensation and withholdings	235,169	245,859
Deferred revenue	93,029	118,826
Actuarial liability for self-insurance	107,514	105,543
Actuarial liability for split-interest agreements	33,968	34,171
Government advances for student loans	22,052	22,113
Commercial paper	214,011	264,075
Long-term debt and capital leases	1,127,458	1,117,029
Fair value of interest rate exchange agreements, net	206,733	315,577
Total liabilities	**2,266,577**	**2,451,615**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt	2,784,933	2,559,802
Unrestricted net assets related to noncontrolling interests	186,901	201,386
Total unrestricted net assets	2,971,834	2,761,188
Temporarily restricted net assets	1,235,066	1,191,216
Permanently restricted net assets	1,132,419	1,067,144
Total net assets	**5,339,319**	**5,019,548**
Total liabilities and net assets	**$ 7,605,896**	**$ 7,471,163**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statement of Activities

Year Ended June 30, 2013 (in thousands)

	2013			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUES AND OTHER SUPPORT				
Tuition and educational fees, net	$ 265,962	$ -	$ -	$ 265,962
Grants and contracts:				
Government sponsors	377,839	-	-	377,839
Private sponsors	61,714	-	-	61,714
Facilities and administrative costs recovery	142,609	-	-	142,609
Total grants and contracts	582,162	-	-	582,162
Contributions	37,940	12,388	60,340	110,668
Endowment distributions	144,801	4,476	1,279	150,556
Investment income	19,675	854	1,337	21,866
Health care services	2,394,341	-	-	2,394,341
Room, board, and other auxiliary services, net	112,929	-	-	112,929
Other sources	53,285	-	-	53,285
Net assets released from restrictions	14,322	(14,322)	-	-
Total revenues and other support	**3,625,417**	**3,396**	**62,956**	**3,691,769**
EXPENSES				
Instruction	489,458	-	-	489,458
Research	447,251	-	-	447,251
Health care services	2,326,339	-	-	2,326,339
Public service	34,039	-	-	34,039
Academic support	158,581	-	-	158,581
Student services	40,921	-	-	40,921
Institutional support	51,518	-	-	51,518
Room, board, and other auxiliary services	120,993	-	-	120,993
Total expenses	**3,669,100**	**-**	**-**	**3,669,100**
Change in unrestricted net assets from operating activity	**(43,683)**			
OTHER CHANGES IN NET ASSETS				
Change in appreciation of endowment, net of distributions	73,019	96,231	-	169,250
Change in appreciation of self-insurance assets	5,232	-	-	5,232
Change in appreciation of other investments	23,149	-	-	23,149
Change in appreciation of interest rate exchange agreements	108,844	-	-	108,844
Contributions for plant	3,757	1,779	-	5,536
Net assets released from restrictions for plant	49,262	(49,262)	-	-
Donor designation changes	5,975	(8,294)	2,319	-
Other	(424)	-	-	(424)
Total other changes in net assets	**268,814**	**40,454**	**2,319**	**311,587**
Increase in net assets controlled by Vanderbilt	**225,131**	**43,850**	**65,275**	**334,256**
Decrease in net assets related to noncontrolling interests	**(14,485)**	**-**	**-**	**(14,485)**
Total increase in net assets	**$ 210,646**	**$ 43,850**	**$ 65,275**	**$ 319,771**
Net assets, June 30, 2012	**$ 2,761,188**	**$ 1,191,216**	**$ 1,067,144**	**$ 5,019,548**
Net assets, June 30, 2013	**$ 2,971,834**	**$ 1,235,066**	**$ 1,132,419**	**$ 5,339,319**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statement of Activities

Year Ended June 30, 2012 (in thousands)

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUES AND OTHER SUPPORT				
Tuition and educational fees, net	$ 250,137	$ -	$ -	$ 250,137
Grants and contracts:				
Government sponsors	397,555	-	-	397,555
Private sponsors	54,768	-	-	54,768
Facilities and administrative costs recovery	147,806	-	-	147,806
Total grants and contracts	600,129	-	-	600,129
Contributions	25,861	28,430	28,580	82,871
Endowment distributions	136,883	8,565	2,447	147,895
Investment income (loss)	19,831	276	(969)	19,138
Health care services	2,461,830	-	-	2,461,830
Room, board, and other auxiliary services, net	109,733	-	-	109,733
Other sources	39,068	-	-	39,068
Net assets released from restrictions	21,459	(21,459)	-	-
Total revenues and other support	**3,664,931**	**15,812**	**30,058**	**3,710,801**
EXPENSES				
Instruction	477,749	-	-	477,749
Research	435,510	-	-	435,510
Health care services	2,220,928	-	-	2,220,928
Public service	45,702	-	-	45,702
Academic support	145,317	-	-	145,317
Student services	35,897	-	-	35,897
Institutional support	37,743	-	-	37,743
Room, board, and other auxiliary services	108,554	-	-	108,554
Total expenses	**3,507,400**	**-**	**-**	**3,507,400**
Change in unrestricted net assets from operating activity	**157,531**			
OTHER CHANGES IN NET ASSETS				
Change in appreciation of endowment, net of distributions	(31,447)	(62,982)	-	(94,429)
Change in appreciation of self-insurance assets	876	-	-	876
Change in appreciation of other investments	(2,476)	-	-	(2,476)
Change in appreciation of interest rate exchange agreements	(180,551)	-	-	(180,551)
Contributions for plant	1,813	-	-	1,813
Net assets released from restrictions for plant	24,210	(24,210)	-	-
Donor designation changes	(11,809)	325	11,484	-
Other	(1,742)	-	-	(1,742)
Total other changes in net assets	**(201,126)**	**(86,867)**	**11,484**	**(276,509)**
(Decrease) increase in net assets controlled by Vanderbilt	**(43,595)**	**(71,055)**	**41,542**	**(73,108)**
Increase in net assets related to noncontrolling interests	**2,137**	**-**	**-**	**2,137**
Total (decrease) increase in net assets	**$ (41,458)**	**$ (71,055)**	**$ 41,542**	**$ (70,971)**
Net assets, June 30, 2011	**$ 2,802,646**	**$ 1,262,271**	**$ 1,025,602**	**$ 5,090,519**
Net assets, June 30, 2012	**$ 2,761,188**	**$ 1,191,216**	**$ 1,067,144**	**$ 5,019,548**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statements of Cash Flows

Years Ended June 30, 2013 and 2012 (in thousands)

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase (decrease) in total net assets	**$ 319,771**	**$ (70,971)**
Adjustments to reconcile change in total net assets to net cash provided by operating activities:		
Decrease (increase) in net assets related to noncontrolling interests	14,485	(2,137)
Net realized gains on investments	(212,662)	(56,783)
Net decrease in unrealized appreciation on investments	15,035	39,985
Contributions for plant and endowment	(72,180)	(59,069)
Contributions of securities other than for plant and endowment	(14,577)	(10,095)
Depreciation and amortization	174,330	172,718
Amortization and reclassification of bond discounts and premiums	(4,922)	1,430
Net (increase) decrease in fair value of interest rate exchange agreements	(108,844)	180,551
(Increase) decrease in:		
Accounts receivable, net of accrued investment income	105,463	(81,640)
Prepaid expenses and other assets	(3,508)	(3,411)
Contributions receivable	2,032	6,238
Interests in trusts held by others	1,166	105
Increase (decrease) in:		
Accounts payable and accrued liabilities, net of nonoperating items	(9,807)	(14,126)
Accrued compensation and withholdings	(10,690)	20,499
Deferred revenue	(25,797)	(6,632)
Actuarial liability for self-insurance	1,971	(5,805)
Actuarial liability for split-interest agreements	(203)	1,396
Net cash provided by operating activities	**171,063**	**112,253**
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(3,770,165)	(2,412,099)
Proceeds from sales of investments	3,712,975	2,231,160
Purchases of investments allocable to noncontrolling interests	(16,398)	(38,707)
Proceeds from sales of investments allocable to noncontrolling interests	65,208	40,815
Increase in accrued investment income	(69)	(239)
Acquisitions of property, plant, and equipment	(223,968)	(143,089)
Proceeds from disposals of property, plant, and equipment	3,984	3,404
Student loans and other notes receivable disbursed	(3,747)	(10,090)
Principal collected on student loans and other notes receivable	5,574	4,888
Net cash used in investing activities	**(226,606)**	**(323,957)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Contributions for plant and endowment	72,180	59,069
(Decrease) increase in government advances for student loans	(61)	1,077
Proceeds from debt issuances	169,603	180,231
Payments to retire or defease debt	(204,316)	(243,950)
Proceeds from noncontrolling interests in investment partnerships	16,398	38,707
Payments to noncontrolling interests in investment partnerships	(65,208)	(40,815)
Net cash used in financing activities	**(11,404)**	**(5,681)**
Net decrease in cash and cash equivalents	**$ (66,947)**	**$ (217,385)**
Cash and cash equivalents at beginning of year	**$ 912,419**	**$ 1,129,804**
Cash and cash equivalents at end of year	**$ 845,472**	**$ 912,419**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Notes to the Consolidated Financial Statements

1. Organization

The Vanderbilt University (Vanderbilt) is a private, coeducational, not-for-profit, nonsectarian institution located in Nashville, Tennessee. Founded in 1873, Vanderbilt owns and operates educational, research, and health care facilities as part of its mission to be a leading center for informed and creative teaching, scholarly research, and public service. Vanderbilt provides educational services to approximately 6,800 undergraduate and 5,900 graduate and professional students enrolled in its 10 schools and colleges.

These consolidated financial statements include the accounts of all entities in which Vanderbilt has a significant financial interest and over which Vanderbilt has control. The patient care enterprise includes Vanderbilt University Hospitals and Clinics; Vanderbilt Medical Group, a physician practice plan; and Vanderbilt Health Services, Inc. (VHS), which includes wholly owned and joint ventured businesses primarily comprised of community physician practices, imaging services, outpatient surgery centers, radiation oncology centers, a home health care agency, a home infusion and respiratory service, an affiliated health network, and a rehabilitation hospital.

All significant intercompany accounts and transactions have been eliminated in consolidation.

2. Summary of Significant Accounting Policies

Basis of Presentation
The consolidated financial statements of Vanderbilt have been prepared on the accrual basis in accordance with U.S. generally accepted accounting principles. Based on the existence or absence of donor-imposed restrictions, Vanderbilt classifies resources into three categories: unrestricted, temporarily restricted, and permanently restricted net assets.

Unrestricted net assets are free of donor-imposed restrictions. All revenues, gains, and losses that are not temporarily or permanently restricted by donors are included in this classification. All expenditures are reported in the unrestricted class of net assets, since the use of restricted contributions in accordance with donors' stipulations results in the release of the restriction.

Temporarily restricted net assets are limited as to use by donor-imposed stipulations that expire with the passage of time or that can be satisfied by action of Vanderbilt. These net assets may include unconditional pledges, split-interest agreements, interests in trusts held by others, and accumulated appreciation on donor-restricted endowments which have not yet been appropriated by the Board of Trust for distribution.

Permanently restricted net assets are amounts required by donors to be held in perpetuity. These net assets may include unconditional pledges, donor-restricted endowments (at historical value), split-interest agreements, and interests in trusts held by others. Generally, the donors of these assets permit Vanderbilt to use a portion of the income earned on related investments for specific purposes.

Expirations of temporary restrictions on net assets, i.e., the passage of time along with the concomitant annual Board of Trust approval of the endowment spending rate, and/or fulfilling donor-imposed stipulations, are reported as net assets released from restrictions between the applicable classes of net assets in the consolidated statements of activities.

Fair Value Measurements
Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosure* (ASC 820) defines fair value, requires expanded disclosures about fair value measurements, and establishes a three-level hierarchy for fair value measurements based on the observable inputs to the valuation of an asset or liability at the measurement date. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820 prioritizes the inputs to the valuation techniques used to measure fair value by giving the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements).

Furthermore, ASC 820 considers certain investment funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. ASC 820 allows for using net asset value per share or its equivalent in estimating the fair value of interests in investment companies for which a readily determinable fair value is not available.

Cash and Cash Equivalents
Cash and cash equivalents are liquid assets with minimal interest rate risk and maturities of three months or less when purchased. Such assets, reported at fair value, primarily consist of depository account balances, money market funds, and short-term U.S. Treasury securities.

Prepaid Expenses and Other Assets
Prepaid expenses and other assets primarily represent inventories, prepaid expenses, and other segregated investment-related assets managed by third parties related to a legacy deferred compensation program that are earmarked to ultimately settle certain liabilities. This latter group of assets, reported at fair value, is excluded from the investments category since Vanderbilt will not directly benefit from the investment return.

Investments
Investments are reported at fair value using the three-level hierarchy established under ASC 820. Fair values for certain alternative investments, mainly investments in limited partnerships where a ready market for the investments does not exist, are based primarily on estimates reported by fund managers. The estimated values are reviewed and evaluated by Vanderbilt.

Vanderbilt has exposure to a number of risks including liquidity, interest rate, counterparty, basis, tax, regulatory, market, and credit risks for both marketable and nonmarketable securities. Due to the level of risk exposure, it is possible that near-term valuation changes for investment securities may occur to an extent that could materially affect the amounts reported in Vanderbilt's financial statements.

Vanderbilt sometimes uses derivatives to manage investment market risks and exposure. Derivatives, which consist of both internally managed transactions and those entered into through external investment managers, are reported at fair value. The most common instruments utilized are futures contracts and hedges against currency translation risk for investments denominated in other than U.S. dollars. For internally managed transactions, Vanderbilt utilizes futures contracts with durations of less than three months.

Purchases and sales of securities are recorded on the trade dates, and realized gains and losses are determined on the basis of the average historical cost of the securities sold. Net receivables and payables arising from unsettled trades are reported as a component of investments.

All endowment investments are managed as an investment pool, unless donor-restricted endowment gift agreements require that they be held separately.

Investments Allocable to Noncontrolling Interests and Net Assets Related to Noncontrolling Interests
For entities in which other organizations are minority equity participants to Vanderbilt's controlling interest, the respective assets are reported separately on the consolidated statements of financial position at fair value as investments allocable to noncontrolling interests.

The balance representing such organizations' minority or noncontrolling interests is recorded based on contractual provisions, which represent an estimate of a settlement value assuming the entity was liquidated in an orderly fashion as of the report date.

Split-Interest Agreements and Interests in Trusts Held by Others
Vanderbilt's split-interest agreements with donors consist primarily of irrevocable charitable remainder trusts, charitable gift annuities, and life income funds for which Vanderbilt serves as trustee. Assets held in these trusts are included in investments at fair value. Contribution revenue is recognized at the dates the trusts are established, net of the liabilities for the present value of the estimated future payments to be made to the donors and/or other beneficiaries. Annually, Vanderbilt records the change in fair value of split-interest agreements based on the assets that are associated with each trust and recalculates the liability for the present value of the estimated future payments to be made to the donors and/or other beneficiaries.

Vanderbilt is also the beneficiary of certain trusts held and administered by others. Vanderbilt's share of these trust assets is recorded at fair value as interests in trusts held by others with any resulting gains or losses reported as investment income.

Property, Plant, and Equipment
Purchased property, plant, and equipment are recorded at cost, including, where appropriate, capitalized interest on construction financing net of income earned on unspent proceeds. Donated assets are recorded at fair value at the date of donation. Repairs and maintenance costs are expensed as incurred. Additions to the library collection are expensed at the time of purchase.

Depreciation is calculated using the straight-line method to allocate the cost of various classes of assets over their estimated useful lives. Property, plant, and equipment are removed from the accounting records at the time of disposal.

Conditional asset retirement obligations related to legal requirements to perform certain future activities associated with the retirement, disposal, or abandonment of assets are accrued utilizing site-specific surveys to estimate the net present value for applicable future costs, e.g., asbestos abatement or removal.

Vanderbilt reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. An impairment charge is recognized when the fair value of the asset or group of assets is less than the carrying value.

Debt Portfolio Financial Instruments
Long-term debt and capital leases are reported at carrying value. The carrying value of Vanderbilt's debt is the par amount adjusted for the net unamortized amount of bond premiums and discounts. Vanderbilt employs derivatives, primarily interest rate exchange agreements, to help manage interest rate risks associated with variable-rate debt. Derivative financial instruments are reported at fair value with any resulting gain or loss recognized as a nonoperating item in the consolidated statements of activities. In addition to the credit risk of the counterparty owing a balance, the fair value of interest rate exchange agreements is based on the present value sum of future net cash settlements that reflect market yields as of the measurement date. Periodic net cash settlement amounts with counterparties are accounted for as adjustments to interest expense on the related debt.

Parties to interest rate exchange agreements are subject to risk for changes in interest rates as well as risk of credit loss in the event of nonperformance by the counterparty. Vanderbilt deals only with high-quality counterparties that meet rating criteria for financial stability and credit worthiness. Additionally, the agreements require the posting of collateral when amounts subject to credit risk under the contracts exceed specified levels.

Revenue Recognition
Vanderbilt's revenue recognition policies are:

Tuition and educational fees, net—Student tuition and educational fees are recorded as revenues during the year the related academic services are rendered. Student tuition and educational fees received in advance of services to be rendered are recorded as deferred revenue. Financial aid provided by Vanderbilt for tuition and educational fees is reflected as a reduction of tuition and educational fees. Financial aid does not include payments made to students for services provided to Vanderbilt.

Grants and contracts, government sponsors—Revenues from government—sponsored grants and contracts are recognized when allowable expenditures are incurred under such agreements.

Grants and contracts, private sponsors—Revenues from private—sponsored grants and contracts are recognized when allowable expenditures are incurred under such agreements.

Facilities and administrative (F&A) costs recovery—F&A costs recovery is recognized as revenue and represents reimbursement, primarily from the federal government, of F&A costs on sponsored activities. Vanderbilt's federal F&A costs recovery rate for on-campus research was 56.0% in fiscal 2013 and 56.0% in fiscal

2012. Vanderbilt's federal F&A costs recovery rate for off-campus research was 28.5% in both fiscal 2013 and 2012.

Health care services—Health care services revenue is reported at established rates, net of contractual adjustments, charity assistance services, and provision for bad debt. Third party contractual revenue adjustments under governmental reimbursement programs are accrued on an estimated basis in the period the related services are rendered. The estimated amounts for Medicare are adjusted as final settlements are determined by Vanderbilt's Medicare Administrative Contractor (MAC).

Vanderbilt implemented the provisions of Accounting Standards Update (ASU) 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07) which specifies that bad debt related to patient service revenue is to be reported as a component of net patient service revenue (contra revenue) for fiscal years beginning after December 15, 2011. Vanderbilt elected to early adopt ASU 2011-07 for fiscal 2012.

Contributions
Unconditional promises to give (pledges) are recognized as contribution revenue when the donor's commitment is received. Pledges with payments due to Vanderbilt in future periods are recorded as increases in temporarily restricted or permanently restricted net assets at the estimated present value of future cash flows, net of an allowance for estimated uncollectible promises. Allowance is made for uncollectible contributions receivable based upon Vanderbilt's analysis of past collection experience and other judgmental factors.

Contributions with donor-imposed restrictions are recorded as unrestricted revenue if those restrictions are met in the same reporting period. Otherwise, contributions with donor-imposed restrictions are recorded as increases in temporarily restricted or permanently restricted net assets, depending on the nature of the restriction.

Contributions recorded as temporarily restricted net assets are released from restrictions and recognized as unrestricted net assets after any donor stipulations are met. Contributions for plant facilities are released from restrictions and recognized as a nonoperating item only after resources are expended for the applicable plant facilities.

In contrast to unconditional promises as described above, conditional promises (primarily bequest intentions) are not recorded until donor contingencies are substantially met.

Operating Results
Operating results (change in unrestricted net assets from operating activity) in the consolidated statements of activities reflect all transactions that change unrestricted net assets, except for nonoperating activity related to endowment and other investments, changes in the fair value of derivative financial instruments, contributions for plant facilities, and certain other nonrecurring items.

Endowment distributions reported as operating revenue consist of endowment return (regardless of when such income arose) distributed to support current operational needs. Vanderbilt's Board of Trust approves the amount to be distributed from the endowment pool on an annual basis, determined by applying a spending rate to an average of the previous three calendar year-end market values. The primary objective of the endowment distribution methodology is to reduce the impact of capital market fluctuations on operational programs.

Operating investment income consists of dividends, interest, and gains and losses on unrestricted, nonendowed investments directly related to core operating activities. Such income includes investment returns on Vanderbilt's working capital assets. For working capital assets invested in long-term pooled investments managed in conjunction with endowment funds, the amount resulting from pre-established distributions from pooled investments is deemed operating investment income; the difference between total returns for these pooled investments and the aforementioned pre-established distributions is reported as nonoperating activity. Operating investment income also excludes investment returns on segregated gift funds and funds set aside for nonoperating purposes such as segregated assets for self-insurance relative to malpractice and professional liability and assets on deposit with trustees.

Management and administrative support costs attributable to divisions that primarily provide health care or auxiliary services are allocated based upon institutional budgets. Thus, institutional support expense separately reported in the consolidated statements of activities relates to Vanderbilt's other primary programs such as instruction, research, and public service.

Costs related to the operation and maintenance of physical plant, including depreciation of plant assets, are allocated to operating programs and supporting activities based upon facility usage. Additionally, interest expense is allocated to the activities that have benefited most directly from the debt proceeds.

Income Taxes
Vanderbilt is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and generally is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Vanderbilt is, however, subject to federal and state income tax on unrelated business income, and provision for such taxes is included in the accompanying consolidated financial statements.

Use of Estimates
The preparation of financial statements requires the use of estimates and assumptions that affect the reported amounts of assets, liabilities, revenues, and expenses during the reporting period as well as the disclosure of contingent assets and liabilities. Actual results ultimately could differ from management's estimates.

Redesignations
When donors amend or clarify intent for applicable contributions reported in a previous fiscal year, revisions are separately reflected as donor designation changes within the consolidated statements of activities.

Reclassifications
Reclassifications within functional expenses and accounts receivable have been made to prior year amounts to conform to the current year presentation.

Subsequent Events
On September 10, 2013, Vanderbilt terminated a $40.0 million notional fixed-payor interest rate exchange agreement with Goldman Sachs at a cost of $6.5 million to reduce interest rate exchange collateral exposure and to eliminate ongoing carrying costs.

3. Accounts Receivable

Accounts receivable as of June 30 were as follows *(in thousands)*:

	2013	2012
Patient care	$ 439,999	$ 535,654
Tuition/fees, grants, and other	95,086	103,861
Accrued investment income	2,079	2,010
Accounts receivable, gross	537,164	641,525
Less: Allowance for bad debts	123,992	122,959
Accounts receivable, net	**$ 413,172**	**$ 518,566**
Days receivable	*41.6*	*51.0*

Gross patient care receivables represented 81.9% and 83.5% of total gross receivables as of June 30, 2013 and 2012, respectively. The largest portion of patient care receivables relates to Vanderbilt University Hospitals and Clinics (the Hospital) and in turn the largest component of the Hospital's receivables was from third party payors.

The Hospital provides services to patients in advance of receiving payment and generally does not require collateral or other security for those services. However, the Hospital routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, TennCare, Blue Cross, health maintenance organizations, or other commercial insurance policies).

During fiscal 2013, due to a noted trend of an increasing balance of aggregate patient care net receivables, along with corresponding cash collections not being realized, Vanderbilt initiated an extensive analysis of its patient care net revenue accounting and estimation processes and systems, including in-depth hindsight liquidation analysis. This analysis resulted in the university recording an unfavorable $121 million change in estimate of the net realizable value of patient receivables during fiscal 2013. This change in estimate is reflected as a reduction of health care services revenue in the accompanying consolidated statements of activities for the year ended June 30, 2013.

As of June 30, the Hospital had receivables, net of related contractual allowances, including estimated amounts for cost reports and other settlements with government payors, from the following payors *(in thousands)*:

	2013	2012
Medicare	$ 54,221	$ 52,282
TennCare/Medicaid	40,480	65,860
Blue Cross	64,910	79,578
Other commercial carriers	84,707	136,195
Patient responsibility	30,941	43,571
Total Hospital receivables, net	**$ 275,259**	**$ 377,486**

Patient care bad debt charges, reported as a reduction to health care services revenue on the consolidated statements of activities, totaled $65.3 million and $65.7 million as of June 30, 2013 and 2012, respectively (both recorded at gross charge level).

4. Contributions Receivable

Contributions receivable as of June 30 were as follows *(in thousands)*:

	2013	2012
Unconditional promises expected to be collected:		
in one year or less	$ 32,285	$ 31,621
between one year and five years	48,229	50,659
in more than five years	1,122	3,509
Contributions receivable	81,636	85,789
Less: Unamortized discount	1,065	1,798
Less: Allowance for uncollectible promises	10,269	11,657
Contributions receivable, net	**$ 70,302**	**$ 72,334**

Contributions receivable are discounted at a rate commensurate with the scheduled timing of receipt. Such amounts outstanding as of June 30, 2013, and June 30, 2012, generally were discounted at rates ranging from 0.5% to 1.5%.

The methodology for calculating an allowance for uncollectible promises is based upon Vanderbilt's analysis of write-offs as a percentage of gross pledges receivable along with assessing the age and activity of outstanding pledges.

In addition to pledges reported as contributions receivable, Vanderbilt had cumulative bequest intentions of approximately $244.0 million and $246.5 million as of June 30, 2013 and 2012, respectively. These intentions to give are not recognized as assets due to their conditional nature.

Contributions receivable, net as of June 30, were classified as follows *(in thousands)*:

	2013	2012
Contributions receivable, net:		
Temporarily restricted	$ 26,555	$ 32,741
Permanently restricted	43,747	39,593
Total	**$ 70,302**	**$ 72,334**

5. Student Loans and Other Notes Receivable

Student loans and other notes receivable, net, as of June 30 along with related allowances for doubtful accounts were as follows *(in thousands)*:

	2013		2012	
	Net Receivable	Related Allowance	Net Receivable	Related Allowance
Federal loans	$ 18,223	$ 1,765	$ 17,979	$ 1,780
Institutional loans	18,376	2,752	20,240	2,733
Faculty mortgages	6,983	-	7,190	-
Student loans and other notes receivable, net	**$ 43,582**		**$ 45,409**	

Vanderbilt remains committed to "no-loans" for its undergraduate students, meaning that the university is meeting full demonstrated financial need with scholarship and grant assistance. For other groups (e.g., professional school students), participation in several federal revolving loan programs, including the Perkins program, has continued. The availability of funds for loans under these programs is dependent on reimbursements to the pool from repayments on outstanding loans. Funds advanced by the federal government ultimately are refundable to the government and are classified as liabilities in the statements of financial position. Outstanding loans cancelled under the program result in a reduction of the funds available for loan and a decrease in the liability to the government.

Included in institutional loans as of June 30, 2013, is an outstanding note receivable of $3.6 million from McKendree Village, LLC, an affiliate of Vanderbilt that has sold all of its operations and is in the process of dissolving. Because it is unlikely McKendree Village, LLC, will be able to repay this debt, it has been fully reserved in the consolidated financial statements.

Allowances for doubtful accounts are established based on prior collection experience and current economic factors which, in management's judgment, could influence the ability of loan recipients to repay amounts due. Institutional loan balances are written off only when they are deemed to be permanently uncollectible.

As part of Vanderbilt's efforts to attract and retain a world-class faculty, Vanderbilt provides home mortgage financing assistance. Notes receivable amounting to $7.0 million were outstanding at June 30, 2013. These notes are collateralized by deeds of trust on properties concentrated in the surrounding region. No allowance for doubtful accounts has been recorded against these loans based on their collateralization and prior collection history.

6. Investments

The fair value of investments consists of the following as of June 30 *(in thousands)*:

	2013	2012
Derivative contract collateral and short-term securities[1]	$ 93,632	$ 259,835
Equity investments		
Developed market equities [2]	652,091	138,400
Emerging market equities [2]	367,423	379,499
Fixed income [1]	268,710	451,220
Absolute return [2]	905,344	678,064
Other hedge funds [2]	92,596	360,369
Private equity [3]	766,243	745,136
Venture capital [3]	488,936	433,306
Real estate [3]	320,124	322,856
Natural resources [3]	341,942	274,183
Equity method securities and trusts[4]	19,853	18,082
Other investments[4]	11,415	12,450
Total fair value	**$ 4,328,309**	**$ 4,073,400**
Total cost	**$ 3,849,347**	**$ 3,570,332**

[1] Fair value is based primarily on quoted prices in active markets.
[2] Fair value is based on the net asset value per share of the specifc investments as provided by the fund managers.
[3] Fair value is based on the net asset value of Vanderbilt's ownership interests at the fund level as provided by the fund managers.
[4] Carrying value provides a reasonable estimate of fair value for certain components.

Included in the amounts reported in the table above are investments allocable to noncontrolling interests (i.e., minority limited partners) reported at fair value. During fiscal 2013, the minority limited partners funded capital commitments totaling $16.4 million. Additionally, Vanderbilt made payments to the minority limited partners of $65.2 million reflecting a distribution of earnings and returned capital from the underlying private fund assets. For the year ended June 30, 2013, the minority limited partners' interests in the results of the underlying returns from the private fund assets were $210.4 million. The balance of unrestricted net assets related to noncontrolling interests, calculated in accordance with the partnership agreements, was $186.9 million as of June 30, 2013.

Investments, along with cash and cash equivalents, provide liquidity support for Vanderbilt's operations. Of these combined amounts, based on prevailing market conditions as of June 30, 2013, $725.8 million was available on a same-day basis and an additional $1,139.3 million was available within 30 days.

Excluding derivative instruments that may be held by investment managers as part of their respective investment strategies, Vanderbilt held financial futures derivative contracts with notional values of $278.7 million and $729.2 million as of June 30, 2013 and 2012, respectively. The fair market value of such contracts is settled daily between counterparties.

Short-term securities and derivative contract collateral are comprised primarily of amounts posted as collateral in accordance with interest rate exchange agreements and unspent bond proceeds with trustees.

Equity investments consist of investment funds globally diversified across public markets including U.S. markets, other developed markets, and emerging markets. Fund managers of these investments have the ability to shift investments from value to growth strategies, from small to large capitalization stocks, and from a net long position to a net short position.

Developed market equities are comprised of investments in U.S. common stocks and other developed countries whose markets have a relatively high level of economic growth and security.

Emerging market equities include investments in the emerging global economies as defined by Morgan Stanley Capital International (MSCI) Emerging Markets Index.

Fixed income investments are directed towards capital preservation and predictable yield as well as more opportunistic strategies focused on generating return on price appreciation. These investments generally consist of U.S. Treasury debt securities, but may also include other highly liquid debt securities.

Absolute return investments reflect multiple strategies such as event driven, relative value, and equity funds to diversify risks and reduce volatility in the portfolio generally in hedge fund structures.

Other hedge fund investments include investments in both long and short primarily credit-oriented securities. Investments may include mortgage—backed securities, trade finance, debt and asset-backed securities, repurchase agreements, senior loans, and bank loans.

Private equity includes investments that participate primarily in leveraged buyout strategies. Distributions from these investments are received through liquidations of the underlying assets. These investments generally are held in commingled limited partnership funds.

Venture capital consists of investments that participate in early-stage, high-potential, high-risk, growth startup companies. These investments generally are held in commingled limited partnership funds. Distributions from these investments are received through liquidations of the underlying assets.

Real estate is comprised of illiquid investments in residential and commercial real estate assets, projects, or land held directly or in commingled limited partnership funds. The nature of the investments in this category is such that distributions generally reflect liquidation of the underlying assets of the funds.

Natural resources includes illiquid investments in timber, oil and gas production, mining, energy, and related services businesses held directly or in commingled limited partnership funds.

Equity method securities and trusts are investments in joint ventures accounted for under the equity method of accounting and Vanderbilt's split-interest agreements with donors.

7. Endowment

Endowment-related assets include donor-restricted endowments and institutional endowments (quasi-endowments). Gift annuities, interests in trusts held by others, contributions pending donor designation, and contributions receivable are not considered components of the endowment.

The Board of Trust's interpretation of its fiduciary responsibilities for donor-restricted endowments under the Uniform Prudent Management of Institutional Funds Act (UPMIFA) requirements, barring the existence of any donor-specific provisions, is to preserve intergenerational equity. Under this broad guideline, future endowment beneficiaries should receive at least the same level of economic support as the current generation. The overarching objective is to preserve and enhance the real (inflation-adjusted) purchasing power of the endowment in perpetuity. Assets are invested to provide a relatively predictable and stable stream of earnings to meet spending needs and attain long-term return objectives without the assumption of undue risks.

UPMIFA specifies that unless stated otherwise in a gift instrument, donor-restricted assets in an endowment fund are restricted assets until appropriated for expenditure. Barring the existence of specific instructions in gift agreements for donor-restricted endowments, Vanderbilt reports the historical value for such endowments as permanently restricted net assets and the net accumulated appreciation as temporarily restricted net assets. In this context, historical value represents the original value of initial contributions restricted as permanent endowments plus the original value of subsequent contributions and, if applicable, the value of accumulations made in accordance with the direction of specific donor gift agreements.

Specific appropriation for expenditure of Vanderbilt's endowment funds occurs each spring when the Board of Trust approves the university's operating budget for the ensuing fiscal year. For fiscal years 2013 and 2012, Vanderbilt's Board of Trust approved endowment distributions based on 4.5% of the average of the previous three calendar year-end market values. Actual realized endowment return earned in excess of distributions is reinvested as part of Vanderbilt's endowment. For years where actual endowment return is less than the distribution, the shortfall is covered by the endowment pool's cumulative returns from prior years.

Board-appropriated endowment distributions may not be fully expended during a particular fiscal year. In some cases, endowment distributions may be approved for reinvestment into the endowment.

A summary of Vanderbilt's endowment for the fiscal years ended June 30 follows (*in thousands*):

2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowments at historical value	$ -	$ 23,454	$ 1,021,892	$ 1,045,346
Accumulated net appreciation of donor-restricted endowments	-	1,136,106	-	1,136,106
Reinvested distributions of donor-restricted endowments				
At historical value	137,686	1,642	-	139,328
Accumulated net appreciation	156,864	1,927	-	158,791
Institutional endowments				
At historical value	265,684	-	-	265,684
Accumulated net appreciation	890,088	-	-	890,088
Endowment net assets as of June 30, 2013	**$ 1,450,322**	**$ 1,163,129**	**$ 1,021,892**	**$ 3,635,343**

2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowments at historical value	$ -	$ 26,889	$ 962,796	$ 989,685
Accumulated net appreciation of donor-restricted endowments	-	1,040,036	-	1,040,036
Reinvested distributions of donor-restricted endowments				
At historical value	133,836	1,641	-	135,477
Accumulated net appreciation	144,321	1,767	-	146,088
Institutional endowments				
At historical value	208,716	-	-	208,716
Accumulated net appreciation	840,034	-	-	840,034
Endowment net assets as of June 30, 2012	**$ 1,326,907**	**$ 1,070,333**	**$ 962,796**	**$ 3,360,036**

The components of the life-to-date accumulated net appreciation of pooled endowments as of June 30 were as follows *(in thousands)*:

	2013	2012
Net realized appreciation less endowment distributions	$ 1,838,135	$ 1,644,115
Net unrealized appreciation	346,850	382,043
Total	**$ 2,184,985**	**$ 2,026,158**

In striving to meet the overarching objectives for the endowment, over the past 20 years, there has been an 11% annualized standard deviation in Vanderbilt's returns. This level of risk is consistent with that accepted by peer institutions. Currently, the endowment portfolio consists of three primary components, each of which is designed to serve a specific role in establishing the right balance between risk and return. Global public and private equity investments, including venture capital and many hedge funds, are expected to produce favorable returns in environments of accelerated growth and economic expansion. Absolute return and fixed income investments are expected to generate stable returns and preserve capital during periods of poor equity performance. Real estate and natural resources allocations are designed to provide an inflation hedge.

From time to time, the fair value of assets associated with an endowed fund may fall below the level that a donor or UPMIFA requires in terms of maintenance of perpetual duration endowments. As of June 30, 2013 and 2012, Vanderbilt had deficiencies of this nature of approximately $6 million consisting of 139 endowments and $11 million consisting of 328 endowments, respectively. These deficiencies resulted from unfavorable market declines that occurred after the investment of recent permanently restricted contributions. Vanderbilt believes these declines are modest in relation to the total market value for donor-restricted endowments and that these deficiencies will be relatively short-term in nature.

Changes in endowment net assets for the fiscal years ended June 30 were as follows (*in thousands*):

2013

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets as of June 30, 2012	$ 1,326,907	$ 1,070,333	$ 962,796	$ 3,360,036
Endowment investment return:				
Investment income, net of fees	63,894	98,211	-	162,105
Net appreciation (realized and unrealized)	61,987	95,278	-	157,265
Total endowment investment return	125,881	193,489	-	319,370
Gifts and additions to endowment, net	60,809	(3,435)	59,096	116,470
Endowment distributions	(59,342)	(91,214)	-	(150,556)
Transfers for internal management costs	(4,104)	(6,309)	-	(10,413)
Other	171	265	-	436
Endowment net assets as of June 30, 2013	**$ 1,450,322**	**$ 1,163,129**	**$ 1,021,892**	**$ 3,635,343**

2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets as of June 30, 2011	$ 1,331,327	$ 1,133,076	$ 910,750	$ 3,375,153
Endowment investment return:				
Investment income, net of fees	15,725	24,672	-	40,397
Net appreciation (realized and unrealized)	4,848	7,607	-	12,455
Total endowment investment return	20,573	32,279	-	52,852
Gifts and additions to endowment, net	35,722	240	52,046	88,008
Endowment distributions	(57,569)	(90,326)	-	(147,895)
Transfers for internal management costs	(3,385)	(5,311)	-	(8,696)
Other	239	375	-	614
Endowment net assets as of June 30, 2012	**$ 1,326,907**	**$ 1,070,333**	**$ 962,796**	**$ 3,360,036**

8. Investment Return

A summary of investment return, including endowment distributions, by net asset category for the fiscal years ended June 30 follows *(in thousands)*:

	2013	2012
OPERATING		
Unrestricted:		
Endowment distributions	$ 144,801	$ 136,883
Investment income	19,675	19,831
Total operating return	**164,476**	**156,714**
NONOPERATING		
Unrestricted:		
Change in appreciation of institutional endowments, net of distributions	73,019	(31,447)
Change in appreciation of self-insurance assets	5,232	876
Investment (loss) income	23,149	(2,476)
Temporarily restricted:		
Endowment distributions	4,476	8,565
Investment income	854	276
Change in appreciation of donor-restricted endowments, net of distributions	96,231	(62,982)
Permanently restricted:		
Endowment distributions	1,279	2,447
Investment (loss) income	1,337	(969)
Total nonoperating return	**205,577**	**(85,710)**
Total investment return	**$ 370,053**	**$ 71,004**

The components of total investment return for the fiscal years ended June 30 were as follows *(in thousands)*:

	2013	2012
Net interest, dividend, and partnership income	$ 173,743	$ 54,210
Net realized gains from original cost	212,662	56,783
Change in unrealized appreciation	(16,352)	(39,989)
Total investment return	**$ 370,053**	**$ 71,004**

In addition to a core group of investment professionals dedicated to the management of Vanderbilt's endowment, Vanderbilt also employs external investment managers. Particularly for alternative investments such as hedge funds, investment manager fee structures frequently have a base component along with a performance component relative to the entire life of the investments. Under these arrangements, management fees frequently are subject to substantial adjustments based on cumulative future returns for a number of years hence.

Investment returns are reported net of returns attributed to limited partners on investments allocable to noncontrolling interests. Investment returns are also reported net of internal management costs of $10.4 million in fiscal 2013 and $8.7 million in fiscal 2012.

Fees paid directly to external investment managers (i.e., segregated investment account fees) totaled $9.6 million and $9.0 million in fiscal 2013 and 2012, respectively.

9. Property, Plant, and Equipment

Property, plant, and equipment as of June 30 were as follows *(in thousands)*:

	2013	2012
Land	$ 73,897	$ 73,859
Buildings and improvements	2,714,757	2,657,197
Moveable equipment	892,230	879,482
Construction in progress	160,893	55,264
Property, plant, and equipment	3,841,777	3,665,802
Less: Accumulated depreciation	2,060,484	1,938,191
Property, plant, and equipment, net	**$ 1,781,293**	**$ 1,727,611**

Purchases for the library collection are not included in the amounts above since they are expensed at the time of purchase. As of June 30, 2013, the estimated replacement cost for library collections, including processing costs to properly identify, catalog, and shelve materials, totaled about $359 million.

No interest was capitalized in either fiscal 2013 or fiscal 2012.

Internally developed software costs of $5.4 million and $7.5 million were capitalized in fiscal 2013 and 2012, respectively.

Vanderbilt has identified conditional asset retirement obligations, primarily for the costs of asbestos removal and disposal, resulting in liabilities of $19.9 million and $20.0 million as of June 30, 2013 and 2012, respectively. These liabilities, which are estimated using an inflation rate of 4.0% and a discount rate of 5.0% based on relevant factors at origination, are included in accounts payable and accrued liabilities in the consolidated statements of financial position.

10. Long-Term Debt, Capital Leases, and Commercial Paper

Long-term debt consists of bonds and notes payable with scheduled final maturity dates at least one year after the original issuance date. Outstanding long-term debt, capital leases, and commercial paper (CP) obligations are reflected in the financial statements at carrying value and, as of June 30, were as follows *(in thousands)*:

	Years to Nominal Maturity	Outstanding Fixed Coupon Interest Rates as of June 30, 2013	Fiscal 2013 Effective Interest Rate[2]	Outstanding Principal 2013	2012
FIXED-RATE DEBT					
Series 2008A	6	4.50%-5.00%	4.0%	$ 117,600	$ 122,600
Series 2008B[1]	6	4.00%-5.00%	3.9%	95,660	105,710
Series 2009A	27	4.00%-5.50%	4.9%	97,100	97,100
Series 2009B[1]	27	5.00%-5.50%	5.0%	232,900	232,900
Series 2009A Taxable	6	5.25%	5.3%	250,000	250,000
Series 2012C	5	2.00%-5.00%	1.1%	25,875	42,315
Series 2012D	25	3.00%-5.00%	3.2%	106,230	-
Series 2012E	7	2.00%-5.00%	0.8%	45,225	-
Fixed-rate debt			4.4%	**970,590**	**850,625**
VARIABLE-RATE DEBT					
Series 2000A			0.3%	-	53,300
Series 2005A			0.3%	-	68,000
Series 2012A	26		0.5%	67,000	67,000
Series 2012B	26		0.7%	67,000	67,000
Variable-rate debt			0.6%	**134,000**	**255,300**
Par amount of long-term debt			3.8%	1,104,590	1,105,925
Net unamortized premium			-	22,341	9,115
Total long-term debt			3.8%	1,126,931	1,115,040
Capital leases	1 to 2		6.0%	527	1,989
Total long-term debt and capital leases			**3.8%**	**1,127,458**	**1,117,029**
Tax-exempt commercial paper	<1		0.3%	99,205	149,205
Taxable commercial paper	<1		0.3%	114,806	114,870
Total commercial paper			**0.3%**	**214,011**	**264,075**
Total long-term debt, capital leases, and commercial paper			**3.2%**	**$ 1,341,469**	**$ 1,381,104**

[1] Issued under Master Trust Indenture structure.

[2] Exclusive of interest rate exchange agreements. Inclusive of these agreements, the overall portfolio effective interest rate was 5.1%.

The preceding table reflects fixed/variable allocations before the effects of interest rate exchange agreements. Such agreements are covered in more detail in a successive note.

Tax-exempt CP and all of the aforementioned bonds (with the exception of the Series 2009A Taxable notes) have been issued by the Health and Educational Facilities Board of The Metropolitan Government of Nashville and Davidson County, Tennessee (HEFB). As a conduit issuer, the HEFB loans the debt proceeds to Vanderbilt. Pursuant to loan agreements, Vanderbilt's debt service requirements under these loan agreements coincide with required debt service of the actual HEFB bonds.

All debt instruments are general obligations of Vanderbilt. No assets are pledged as collateral for such debt.

Included in the foregoing table are hospital and clinic (patient care) bonds, with a principal balance outstanding of $328.6 million as of June 30, 2013, that were issued under a Master Trust Indenture (MTI) structure. The MTI provides the flexibility for multiple parties to participate in debt issuances as part of an obligated group; presently, Vanderbilt's hospitals and clinics have no other members participating in the obligated group. Bonds issued under the MTI are payable from hospital revenues. All outstanding MTI bonds are also supplemented by a Vanderbilt guarantee of debt service.

Trust indentures for certain bond issues contain covenants and restrictions involving the issuance of additional debt, maintenance of a specified debt service coverage ratio, and the maintenance of liquidity facilities. Vanderbilt was in compliance with such covenants and restrictions as of June 30, 2013.

Selected information for debt, CP, and interest rate exchange agreements follows *(in thousands)*:

	2013	2012
Payments for interest costs	$ 71,475	$ 72,125
Accrued interest expense	$ 68,108	$ 67,977

Payments for interest costs, including amounts capitalized, occur on varying scheduled payment dates for debt, maturity dates for CP, and settlement dates for interest rate exchange agreements. Accrued interest expense is based on applicable interest rates for Vanderbilt's debt, CP, and interest rate exchange agreements for the respective fiscal year.

Principal retirements and scheduled sinking fund requirements based on nominal maturity schedules for long-term debt due in subsequent fiscal years ending June 30 are as follows *(in thousands)*:

2014	$ 38,465
2015	40,240
2016	54,245
2017	44,875
2018	47,070
Thereafter	879,695
Total long-term debt principal retirements	**$ 1,104,590**

In addition to scheduled principal and interest payments on long-term debt obligations, Vanderbilt's capital lease agreements outstanding as of June 30, 2013, will require payments of $0.4 million during fiscal 2014. Of those payments, $0.4 million will be allocated toward amortizing the $0.5 million capital lease obligation. Furthermore, requirements noted in the preceding table could be greater if Vanderbilt must purchase either a portion or all of its floating-rate notes or CP in the event of failed remarketings, on mandatory tender dates, or scheduled maturities as described in the following paragraphs.

Vanderbilt had $134.0 million of variable-rate bonds outstanding as of June 30, 2013, consisting entirely of floating-rate notes with mandatory tender dates of October 1, 2015 and 2017.

As of June 30, 2013, Vanderbilt had $99.2 million of tax-exempt CP outstanding and $114.8 million of taxable CP outstanding. Vanderbilt can issue up to a combined $675.0 million under its tax-exempt and taxable CP programs. However, issuance of incremental taxable CP beyond that outstanding as of June 30, 2013, would require approval by Vanderbilt's Board of Trust, and issuance of incremental tax-exempt CP would require approval by both Vanderbilt's Board of Trust and the HEFB as conduit issuer.

The weighted average duration of Vanderbilt's CP portfolio totaled 106 days as of June 30, 2013, and 151 days as of June 30, 2012.

Liquidity support for debt with short-term remarketing periods (CP totaling $214.0 million) is provided by Vanderbilt's self-liquidity. As of June 30, 2013, Vanderbilt estimates that $725.8 million of liquid assets were available on a same-day basis and an additional $1,139.3 million was available within 30 days.

A second tier of liquidity support consists of two bank revolving credit facilities with maximum available commitments totaling $400.0 million as of June 30, 2013, dedicated to Vanderbilt's debt portfolio liquidity support; one of these lines totaling $200.0 million includes a general use provision. These commitments expire in March 2014 and March 2016. The maximum repayment period, which may extend beyond the expiration date, ranges from 90 days to three years. Vanderbilt has never borrowed against revolving credit agreements to support redemptions of debt.

Vanderbilt has also entered into an agreement with one bank to provide a general use line of credit with a maximum available commitment totaling $100.0 million as of June 30, 2013. This line of credit expires in October 2014. No amounts were drawn on these credit facilities as of June 30, 2013, or June 30, 2012.

Vanderbilt's long-term debt is reported at carrying value, which is the par amount adjusted for the net unamortized amount of bond premiums and discounts. The carrying value and estimated market value of Vanderbilt's long-term debt as of June 30 were as follows *(in thousands)*:

	2013	2012
Carrying value of long-term debt	$ 1,126,931	$ 1,115,040
Market value of long-term debt	$ 1,196,940	$ 1,205,749

The estimated market value of Vanderbilt's long-term debt is based on market conditions prevailing at fiscal year-end reporting dates. Besides potentially volatile market conditions, market value estimates typically also reflect limited secondary market trading. Vanderbilt's capital leases and commercial paper are also reported at carrying value, which closely approximates market value for those liabilities.

On November 29, 2012, Vanderbilt issued Series 2012D and 2012E bonds aggregating $151.4 million for the purpose of redeeming weekly reset variable-rate debt and tax-exempt commercial paper. The Series 2012D fixed-rate bonds were issued in the par amount of $106.2 million and include an original issue premium of $13.4 million. The proceeds from Series 2012D were used to fund the full redemption of Vanderbilt's variable-rate Series 2000A and 2005A-1. The Series 2012D bonds have an average coupon of 3.9% and a final maturity of October 1, 2037. The Series 2012E fixed-rate bonds were issued in the par amount of $45.2 million and include an original issue premium of $4.8 million. The proceeds from Series 2012E were used to refund $50.0 million of tax-exempt commercial paper. The Series 2012E bonds are noncallable with an average coupon of 3.5% and a final maturity of October 1, 2019.

None of Vanderbilt's fixed-rate debt has a mandatory tender date preceding the respective final maturity date. The Series 2008A and 2008B bonds include amortizing principal amounts each year but these bonds are noncallable before their October 2018 final maturity date. The Series 2009A and 2009B bonds include amortizing principal amounts each year beginning fiscal 2016 and these bonds may be called at par beginning October 2019. The Series 2009A Taxable notes do not amortize and are callable before the April 2019 maturity date only if Vanderbilt pays a make-whole call provision to the bondholders. The Series 2012C bonds include annual amortizing principal amounts each year, excluding October 2015, until their final maturity in October 2017. The Series 2012D bonds include amortizing principal amounts each year beginning in fiscal 2021 and may be called at par beginning October 2023. The Series 2012E bonds include annual amortizing principal amounts beginning October 2013, until their final maturity in October 2019.

11. Interest Rate Exchange Agreements

Vanderbilt has entered into interest rate exchange agreements as part of its debt portfolio management strategy. These agreements result in periodic net cash settlements paid to, or received from, counterparties. Net settlements due to counterparties totaled $25.8 million and $25.5 million in fiscal 2013 and 2012, respectively, and were reflected as adjustments to interest expense.

The fair value of interest rate exchange agreements is based on the present value sum of future net cash settlements that reflect market yields as of the measurement date and reflects estimated amounts that Vanderbilt would pay, or receive, to terminate the contracts as of the report date. The estimated fair value of Vanderbilt's outstanding interest rate exchange agreements was a liability of $206.7 million and a liability of $315.6 million as of June 30, 2013 and 2012, respectively.

Vanderbilt did not enter into any new interest rate exchange agreements during fiscal 2013 or 2012. In October 2012, Vanderbilt novated $200 million of fixed-payor interest rate exchange agreements in order to diversify counterparty risk and reduce the university's aggregate collateral posting requirements. Following the novation and scheduled amortizations, Vanderbilt had $718.2 million of aggregate fixed-payor interest rate exchange agreements outstanding for which the university receives 68.3% of one-month LIBOR and pays a weighted average fixed rate of 3.78%.

Gains and losses from changes in the fair value of interest rate exchange agreements are reported in the nonoperating section of the consolidated statements of activities. These changes resulted in net gains of $108.9 million in fiscal 2013 and net losses of $180.6 million in fiscal 2012.

The interest rate exchange agreements include collateral pledging requirements based on the fair value of the contracts. Collateral held by counterparties as of June 30, 2013 and 2012, totaled $95.1 million and $236.2 million, respectively. Vanderbilt estimates that a decline in long-term LIBOR rates to approximately 2% would result in the fair value of the portfolio being a liability of approximately $420 million and correspondingly increase Vanderbilt's collateral pledging requirements to approximately $280 million. As of June 30, 2013, 30-year LIBOR was 3.45%.

As of June 30, 2013, Vanderbilt's adjusted debt portfolio, after taking into account outstanding fixed-payor interest rate exchange agreements, was approximately 128% fixed.

The notional amounts of Vanderbilt's outstanding interest rate exchange agreements as of June 30 were as follows *(in thousands)*:

Description	Rate Paid	Rate Received	Maturity	2013	2012
Fixed-payor interest rate exchange agreements[1]	Avg fixed rate of 3.78%	Avg of 68.3% of one-month LIBOR[2]	18 to 32 years	$ 718,200	$ 721,600
Basis interest rate exchange agreements	SIFMA[3]	Avg of 81.5% of one-month LIBOR[2]	22 to 23 years	$ 500,000	$ 500,000

[1] For one amortizing fixed-payor interest rate exchange agreement that has a notional balance of $51.6 million as of June 30, 2013, the counterparty may exercise an option to terminate the contract, in whole or in part and at no cost, at any time from that date until the final maturity in October 2030.
[2] LIBOR (London Interbank Offered Rate) is a reference rate based on interest rates at which global banks borrow funds from other banks in the London interbank lending market.
[3] SIFMA (Securities Industry and Financial Markets Association) is a seven-day high-grade market index rate based upon tax-exempt variable rate debt obligations.

12. Net Assets

Unrestricted net assets are internally designated into the following groups:

Designated for operations represents the cumulative operating activity of Vanderbilt and plant replacement reserves. These net assets also reflect the realized losses of derivative financing activities.

Designated gifts and grants are composed of gift and grant funds.

Designated for student loans represents Vanderbilt funds set aside to serve as revolving loan funds for students.

Designated for plant facilities represents (a) Vanderbilt's investment in property, plant, and equipment, net of accumulated depreciation, as well as (b) funds designated for active construction projects and retirement of capital-related debt, offset by (c) Vanderbilt's conditional asset retirement obligation.

Reinvested distributions of donor-restricted endowments at historical value are amounts related to donor-restricted endowments that are reinvested in the endowment in accordance with donor requests.

Accumulated net appreciation of reinvested distributions represents cumulative appreciation on reinvestments of donor-restricted endowments.

Institutional endowments (quasi-endowments) *at historical value* are amounts set aside by Vanderbilt to generate income in perpetuity to support operating needs.

Accumulated net appreciation of institutional endowments represents cumulative appreciation on institutional endowments.

Fair value of interest rate exchange agreements, net represents the mark-to-market valuation for such contracts. Because these agreements are intended to manage interest rate risks within the debt portfolio, segregation from other designations is maintained.

Net assets related to noncontrolling interests represents minority partners' share of the equity in two partnerships (endowment pri-

vate equity and real estate partnerships) formed to acquire, hold, and manage private fund assets.

Based on the foregoing designations, unrestricted net assets as of June 30 were as follows *(in thousands)*:

	2013	2012
Designated for operations	$ 688,845	$ 693,025
Designated gifts and grants	103,438	118,023
Designated for student loans	23,096	22,480
Designated for plant facilities	725,965	714,944
Reinvested distributions of donor-restricted endowments at historical value	137,686	133,836
Accumulated net appreciation of reinvested distributions	156,864	144,321
Institutional endowments at historical value	265,684	208,716
Accumulated net appreciation of institutional endowments	890,088	840,034
Fair value of interest rate exchange agreements, net	(206,733)	(315,577)
Net assets related to noncontrolling interests	186,901	201,386
Total unrestricted net assets	**$ 2,971,834**	**$ 2,761,188**

Temporarily restricted net assets as of June 30 were composed of the following *(in thousands)*:

	2013	2012
Donor-restricted endowments at historical value	$ 23,454	$ 26,889
Accumulated net appreciation of donor-restricted endowments	1,136,106	1,040,036
Reinvested distributions of donor-restricted endowments at historical value	1,642	1,641
Accumulated net appreciation of reinvested distributions	1,927	1,767
Contributions	52,335	101,603
Interests in trusts held by others	6,233	6,826
Life income and gift annuities	13,369	12,454
Total temporarily restricted net assets	**$ 1,235,066**	**$ 1,191,216**

Such temporarily restricted net assets were designated for the following purposes as of June 30 *(in thousands)*:

	2013	2012
Student scholarships	$ 391,674	$ 353,543
Endowed chairs	332,416	301,373
Operations	258,606	234,383
Program support	90,481	81,097
Capital improvements	11,505	16,183
Subsequent period operations and other	150,384	204,637
Total temporarily restricted net assets	**$ 1,235,066**	**$ 1,191,216**

Permanently restricted net assets as of June 30 were composed of the following *(in thousands)*:

	2013	2012
Donor-restricted endowments at historical value	$ 1,021,892	$ 962,796
Contributions	44,255	40,101
Interests in trusts held by others	31,859	32,431
Life income and gift annuities	34,413	31,816
Total permanently restricted net assets	**$ 1,132,419**	**$ 1,067,144**

Based on relative fair values as of June 30, 2013, donor-restricted endowments supported the following:

	2013	2012
Financial aid	34%	34%
Endowed chairs	29%	29%
Operations	22%	21%
Program support	8%	8%
Research, lectureships, fellowships, and other	7%	8%
Total support	**100%**	**100%**

13. Fair Value Measurement

Vanderbilt utilizes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three levels:

Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that are accessible at the measurement date.

Level 2 inputs are inputs other than quoted prices included in Level 1 that are either directly or indirectly observable for the assets or liabilities.

Level 3 inputs are unobservable inputs for the assets or liabilities.

The level in the fair value hierarchy within which a fair value measurement in its entirety is classified is based on the lowest level input that is significant to the fair value measurement.

The classification of a financial instrument within level 3 is based on the significance of the unobservable inputs to the overall fair value measurement.

All net realized and unrealized gains and losses on level 3 investments are reflected in the consolidated statements of activities as changes in endowment appreciation or changes in appreciation of other investments. Gains and losses on investments allocable to noncontrolling interests are reported as a component of net endowment appreciation in the consolidated statements of activities. Net realized and unrealized gains and losses on interests in trusts held by others are reported as changes in appreciation of other investments in the consolidated statements of activities.

Rollforwards of amounts for level 3 financial instruments for the fiscal years ended June 30 follow *(in thousands)*:

	June 30, 2012	Realized and unrealized gains (losses)	Purchases	Sales	Transfers into and (out) of level 3	June 30, 2013	Change in unrealized gains (losses) for investments still held at June 30, 2013
LEVEL 3 ASSETS							
Developed market equities	$ 32,523	2,552	193,470	(206,288)	-	22,257	(96,679)
Emerging market equities	108,343	(2,354)	-	(13,000)	-	92,989	(2,354)
Fixed income	19,754	(652)	1,503	(2,339)	774	19,040	2,898
Absolute return	507,989	52,613	116,975	(147,536)	-	530,041	48,981
Other hedge funds	191,688	1,410	91,186	(191,688)	-	92,596	1,410
Private equity	745,136	83,745	114,456	(177,094)	-	766,243	18,218
Venture capital	433,306	55,894	61,968	(63,080)	-	488,088	28,053
Real estate	322,856	16,224	39,790	(58,194)	(552)	320,124	(17,864)
Natural resources	274,183	2,951	170,477	(105,669)	-	341,942	(1,763)
Equity method securities and trusts	18,082	11,265	853	(1,824)	(8,523)	19,853	4,878
Other investments	12,309	(1,193)	60	-	-	11,176	5
Interests in trusts held by others	39,257	(1,166)	-	-	-	38,091	(1,061)
Total Level 3	**$ 2,705,426**	**$ 221,289**	**$ 790,738**	**$ (966,712)**	**$ (8,301)**	**$ 2,742,440**	**$ (15,278)**

	June 30, 2011	Realized and unrealized gains (losses)	Purchases	Sales	Transfers into and (out) of level 3	June 30, 2012	Change in unrealized gains (losses) for investments still held at June 30, 2012
LEVEL 3 ASSETS							
Developed market equities	$ 70,225	(7,295)	7,867	(38,274)	-	32,523	(3,014)
Emerging market equities	134,448	(19,855)	-	(6,250)	-	108,343	(19,856)
Fixed income	19,706	581	6,981	(7,514)	-	19,754	(1,249)
Absolute return	612,815	(24,022)	5,773	(86,577)	-	507,989	(122,215)
Other hedge funds	182,937	8,751	-	-	-	191,688	8,751
Private equity	754,233	4,088	89,647	(102,832)	-	745,136	43,423
Venture capital	395,621	35,724	69,996	(68,035)	-	433,306	2,125
Real estate	269,553	43,565	45,694	(35,956)	-	322,856	170,196
Natural resources	255,343	11,695	37,948	(30,803)	-	274,183	(10,629)
Equity method securities and trusts	18,367	7,847	3,609	(3,424)	(8,317)	18,082	(7,032)
Other investments	23,779	(6,344)	2,793	(8,133)	214	12,309	17,325
Interests in trusts held by others	39,362	(105)	-	-	-	39,257	(105)
Total Level 3	**$ 2,776,389**	**$ 54,630**	**$ 270,308**	**$ (387,798)**	**$ (8,103)**	**$ 2,705,426**	**$ 77,720**

The tables on the following pages present the amounts within each valuation hierarchy level for those assets and liabilities carried at fair value: cash and cash equivalents; investments; investments allocable to noncontrolling interests (in Vanderbilt-controlled real estate and other partnerships); interests in trusts held by others; and the fair value of interest rate exchange agreements, net.

As a measure of liquidity, the frequencies that investments may be redeemed or liquidated are also noted in the following tables, along with the numbers of days notice required to liquidate investments.

As of June 30, 2013, 86% of cash and cash equivalents were available on a same-day basis.

Most investments that have been classified as levels 2 and 3 consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings. Since the net asset value reported by each fund is used as a practical expedient to estimate the fair value of Vanderbilt's interest therein, its classification within the fair value hierarchy as level 2 or level 3 is based on Vanderbilt's ability to redeem its interest at or near the financial statement date. Vanderbilt defines near-term as within 90 days of the financial statement date.

Derivative contract collateral and short-term securities are comprised primarily of amounts posted as collateral in accordance with interest rate exchange agreements and unspent bond proceeds with trustees. Vanderbilt deems a redemption or liquidation frequency for these amounts as nonapplicable.

Equities and fixed income provide varying levels of liquidity as defined in the following tables. As of June 30, 2013, 74%, 64%, and 76% of developed market equities value, emerging market equities

value, and fixed income value, respectively, were available for daily redemption requests with liquidity within 30 days.

Absolute return and other hedge funds includes daily, quarterly, and annual redemption frequencies. Notice may be provided to the fund managers to exit from the respective funds in the time periods noted.

As of June 30, 2013, 20% of absolute return investments were comprised of hedge funds in "hard lockup" periods of up to 36 months, during which redemptions or liquidations are not allowed per terms of the respective agreements with fund managers. Additionally, 6% of absolute return investments were in "soft lockup" periods of up to nine months, during which redemptions or liquidations may occur but are subject to withdrawal penalties of up to 4.5%.

The total fair values for private equity, venture capital, real estate, natural resources, and other investments were reported as illiquid as of June 30, 2013. These amounts predominantly consist of limited partnerships. Under the terms of these limited partnership agreements, Vanderbilt is obligated to remit additional funding periodically as capital calls are exercised by the general partner. These partnerships have a limited existence and the agreements may provide for annual extensions relative to the timing for disposing portfolio positions and returning capital to investors. Depending on market conditions, the ability or inability of a fund to execute its strategy, and other factors, the general partner may extend the terms or request an extension of terms of a fund beyond its originally anticipated existence or may liquidate the fund prematurely. Vanderbilt cannot anticipate such changes because they are based on unforeseen events. As a result, the timing and amount of future capital calls or distributions in any particular year are uncertain and the related market values are reported as illiquid.

The following tables summarize the fair value measurements and terms for redemptions or liquidations for those assets and liabilities carried at fair value as of June 30 *(in thousands)*:

2013

	Fair Value Measurements				Group	Redemption or Liquidation	Days
	Level 1	Level 2	Level 3	Total	%	Frequency	Notice
ASSETS REPORTED AT FAIR VALUE							
Cash and cash equivalents	$ 845,472	$ -	$ -	$ 845,472	86%	Daily	same-day
					14%	Daily	2-90 days
Derivative contract collateral and short-term securities	93,632	-	-	93,632	100%	n/a	n/a
Equity investments:							
Developed market equities	625,101	4,733	22,257	652,091	74%	Daily	2-30 days
					15%	Daily	next day
					10%	Daily	>30 days
					1%	Annually	>30 days
Emerging market equities	274,434	-	92,989	367,423	64%	Daily	2-30 days
					24%	Monthly	>30 days
					12%	Quarterly	>30 days
Fixed income	249,670	-	19,040	268,710	76%	Daily	next-day
					24%	Daily	>30 days
Absolute return	59,915	315,388	530,041	905,344	44%	Quarterly	>30 days
					16%	Annually	>30 days
					26%	Lockup	>30 days
					13%	n/a	>30 days
					1%	n/a	n/a
Other hedge funds	-	-	92,596	92,596	100%	Annually	>30 days
Private equity	-	-	766,243	766,243	1%	n/a	>30 days
					99%	n/a	n/a
Natural resources	-	-	341,942	341,942	81%	n/a	n/a
					19%	Quarterly	>30 days
Venture capital	848	-	488,088	488,936	100%	>1yr	n/a
Real estate	-	-	320,124	320,124	100%	>1yr	n/a
Equity method securities and trusts	-	-	19,853	19,853	100%	>1yr	n/a
Other investments	239	-	11,176	11,415	100%	>1yr	n/a
Interests in trusts held by others	-	-	38,091	38,091	100%	n/a	n/a
Total assets reported at fair value	**$ 2,149,311**	**$ 320,121**	**$ 2,742,440**	**$ 5,211,872**			
LIABILITIES REPORTED AT FAIR VALUE							
Interest rate exchange agreements, net	**$ -**	**$ 206,733**	**$ -**	**$ 206,733**			

2012

	Fair Value Measurements				Group	Redemption or Liquidation	Days
	Level 1	Level 2	Level 3	Total	%	Frequency	Notice
ASSETS REPORTED AT FAIR VALUE							
Cash and cash equivalents	$ 912,419	$ -	$ -	$ 912,419	87%	Daily	same-day
					13%	Daily	2-90 days
Derivative contract collateral and short-term securities	259,835	-	-	259,835	100%	n/a	n/a
Equity investments:							
Developed market equities	101,637	4,240	32,523	138,400	47%	Daily	2-30 days
					43%	Daily	>30 days
					3%	Annually	>30 days
					7%	n/a	n/a
Emerging market equities	271,156	-	108,343	379,499	63%	Daily	2-30 days
					22%	Monthly	>30 days
					15%	Quarterly	>30 days
Fixed income	431,466	-	19,754	451,220	51%	Daily	next-day
					34%	Daily	2-30 days
					15%	Daily	>30 days
Absolute return	82,847	87,228	507,989	678,064	5%	Daily	2-30 days
					57%	Quarterly	>30 days
					9%	Annually	>30 days
					26%	Lockup	>30 days
					3%	n/a	n/a
Other hedge funds	-	168,681	191,688	360,369	28%	Daily	>30 days
					27%	Quarterly	>30 days
					45%	Annually	>30 days
Private equity	-	-	745,136	745,136	100%	>1yr	n/a
Venture capital	-	-	433,306	433,306	100%	>1yr	n/a
Real estate	-	-	322,856	322,856	100%	>1yr	n/a
Natural resources	-	-	274,183	274,183	100%	>1yr	n/a
Equity method securities and trusts	-	-	18,082	18,082	100%	n/a	n/a
Other investments	141	-	12,309	12,450	100%	>1yr	n/a
Interests in trusts held by others	-	-	39,257	39,257	100%	n/a	n/a
Total assets reported at fair value	**$ 2,059,501**	**$ 260,149**	**$ 2,705,426**	**$ 5,025,076**			
LIABILITIES REPORTED AT FAIR VALUE							
Interest rate exchange agreements, net	$ -	$ 315,577	$ -	$ 315,577			

14. Retirement Plans

Vanderbilt's full-time faculty and staff members participate in defined contribution retirement plans administered by third-party investment and insurance firms. For eligible employees with one year of continuous service, these plans require employee and matching employer contributions. Such contributions immediately fully vest with the employee.

Vanderbilt's obligations under these plans are fully funded by monthly transfers to the respective retirement plan administrators with the corresponding expenses recognized in the year incurred. Vanderbilt's retirement plan contributions for fiscal 2013 and 2012 were $63.0 million and $59.8 million, respectively.

15. Student Financial Aid

Vanderbilt provides financial aid to students based upon need and merit. This financial assistance is funded by institutional resources, contributions, endowment distributions, and externally sponsored programs.

In fiscal 2013 and 2012, financial aid for tuition and educational fees of $209.9 million and $199.3 million was applied to gross tuition and educational fees of $475.9 million and $449.4 million, respectively. In fiscal 2013 and 2012, financial aid for room and board of $29.2 million and $28.8 million was applied to gross room and board of $69.0 million and $70.1 million, respectively.

Loans to students from Vanderbilt funds are carried at cost, which, based on secondary market information, approximates the fair value of educational loans with similar interest rates and payment terms. Loans to qualified students historically have been funded principally with government advances to Vanderbilt under the Perkins, Nursing, and Health Professions Student Loan Programs. Loans receivable from students under governmental loan programs, also carried at cost, can only be assigned to the federal government or its designees. Student loan receivables are reported net of allowances for estimated uncollectible accounts of $4.5 million as of June 30, 2013 and 2012.

16. Natural Classification of Expenses and Allocations

For the fiscal years ended June 30, operating expenses incurred were as follows *(in thousands)*:

	2013	2012
Salaries, wages, and benefits	$ 2,277,192	$ 2,195,716
Services	208,796	188,488
General expenses and supplies	780,529	726,116
Depreciation and amortization	174,330	172,718
Interest	68,108	67,977
Utilities, operating leases, and other	160,145	156,385
Total operating expenses	**$ 3,669,100**	**$ 3,507,400**

Certain allocations of institutional and other support costs were made to Vanderbilt's primary programs. Based on the functional uses of space on its campus, Vanderbilt allocated depreciation and interest on indebtedness to the functional operating expense categories as shown below *(in thousands)*:

2013

	Depreciation	Interest
Instruction	$ 19,274	$ 3,086
Research	26,784	6,022
Health care services	80,239	41,319
Public service	821	103
Academic support	8,419	1,155
Student services	1,249	355
Institutional support	14,809	1,948
Room, board, and other auxiliary services	22,735	14,120
Total	**$ 174,330**	**$ 68,108**

2012

	Depreciation	Interest
Instruction	$ 19,295	$ 3,359
Research	27,080	6,276
Health care services	78,548	42,731
Public service	816	100
Academic support	8,241	1,210
Student services	1,207	428
Institutional support	15,117	1,781
Room, board, and other auxiliary services	22,414	12,092
Total	**$ 172,718**	**$ 67,977**

17. Charity Care Assistance and Community Benefits

VUMC (including hospitals, clinics, and physician practice units) maintains a policy which sets forth the criteria pursuant to those health care services that are provided without expectation of payment, or, at a reduced payment rate to patients who have minimal financial resources to pay for their medical care. These services represent charity care and are not reported as revenue.

The medical center maintains records to identify and monitor the level of charity care it provides, and these records include the amount of gross charges and patient deductibles, co-insurance and co-payments forgone for services furnished under its charity care policy, and the estimated cost of those services. Charity care assistance is offered on a tiered grid, which is based on federal poverty guidelines. In addition to charity care assistance, all uninsured patients are eligible for a discount from billed charges for medically necessary services that is mandated under state of Tennessee law. For those patients with a major catastrophic medical event that does not qualify for full charity assistance, additional discounts are given based on the income level of the patient household using a sliding scale.

The total cost of uncompensated care (comprising charity care and bad debt) was $137.8 million and $134.3 million for fiscal 2013 and 2012, respectively. Of the total uncompensated care, charity care represented 85.3% and 84.8% in fiscal 2013 and 2012, respectively.

In addition to the charity care services described above, the medical center provides a number of other services to benefit the economically disadvantaged for which little or no payment is received. TennCare/Medicaid and state indigent programs do not cover the full cost of providing care to beneficiaries of those programs. As a result, in addition to direct charity care costs, the medical center provided services related to TennCare/Medicaid and state indigent programs substantially below the cost of rendering such services.

The medical center also provides public health education and training for new health professionals and provides, without charge, services to the community at large, together with support groups for many patients with special needs.

18. Related Parties

Intermittently, members of Vanderbilt's Board of Trust or Vanderbilt employees may be directly or indirectly associated with companies engaged in business activities with the university. Accordingly, Vanderbilt has a written conflict of interest policy that requires, among other things, that members of the university community (including trustees) may not review, approve, or administratively control contracts or business relationships when (a) the contract or business relationship is between Vanderbilt and a business in which the individual or a family member has a material financial interest or (b) the individual or a family member is an employee of the business and is directly involved with activities pertaining to Vanderbilt.

Furthermore, Vanderbilt's conflict of interest policy extends beyond the foregoing business activities in that disclosure is required for any situation in which an applicable individual's financial, professional, or other personal activities may directly or indirectly affect, or have the appearance of affecting, an individual's professional judgment in exercising any university duty or responsibility, including the conduct or reporting of research.

The policy extends to all members of the university community (including trustees, university officials, and faculty and staff and their immediate family members). Each applicable person is required to certify compliance with the conflict of interest policy on an annual basis. This certification includes specifically disclosing whether Vanderbilt conducts business with an entity in which he or she (or an immediate family member) has a material financial interest as well as any other situation that potentially could be perceived to conflict with Vanderbilt's best interests.

When situations exist relative to the conflict of interest policy, active measures are taken to appropriately manage the actual or perceived conflict in the best interests of the university, including periodic reporting of the measures taken to the Board of Trust Audit Committee.

19. Lease Obligations

Vanderbilt leases certain equipment and real property. These leases are classified primarily as operating leases and have lease terms of up to 15 years. Total operating lease expense in fiscal 2013 and 2012 was $64.7 million and $56.1 million, respectively.

As of June 30, 2013, future committed minimum rentals by fiscal year on significant noncancelable operating leases with initial or remaining lease terms in excess of one year were as follows *(in thousands)*:

2014	$ 40,428
2015	38,362
2016	30,270
2017	25,079
2018	19,879
Thereafter	37,315
Total future minimum rentals	**$ 191,333**

20. Commitments and Contingencies

(A) *Construction.* As of June 30, 2013, approximately $123.7 million was contractually committed for projects under construction and equipment purchases. The largest components of these commitments were for the second phase of Vanderbilt's residential colleges program, College Halls at Kissam ($81.0 million); Vanderbilt Recreation and Wellness Center expansion ($14.0 million); and floor build-outs in the Critical Care Tower of the adult hospital ($10.8 million).

(B) *Litigation.* Vanderbilt is a defendant in several legal actions. One such legal action is a qui tam civil action related to billing and government reimbursement for certain professional health care services provided by the Vanderbilt University Medical Center. The lawsuit is related to an ongoing civil investigation by the U.S. Department of Justice and the Office of Inspector General for the Department of Health and Human Services and Vanderbilt is fully cooperating with the investigation. Vanderbilt believes that the outcome of these actions will not have a significant effect on its consolidated financial position.

(C) *Regulations.* Vanderbilt's compliance with regulations and laws is subject to future government reviews and interpretations, as well as regulatory actions unknown or unasserted at this time. Vanderbilt believes that the liability, if any, from such reviews will not have a significant effect on Vanderbilt's consolidated financial position.

D) *Medical Malpractice Liability Insurance.* Vanderbilt is self-insured for the first level of medical malpractice claims. The current self-insured retention is $5.5 million per occurrence, not to exceed an annual aggregate of $43.0 million. For this self-insured retention, investments have been segregated. The funding for these segregated assets is based upon studies performed by an independent actuarial firm. Excess malpractice and professional liability coverage has been obtained from commercial insurance carriers on a claims-made basis for claims above the retained self-insurance risk levels.

(E) *Employee Health and Workers Compensation Insurance.* Vanderbilt is self-insured for employee health insurance and workers compensation coverage. Vanderbilt's estimated liabilities are based upon studies conducted by independent actuarial firms.

(F) *Federal and State Contracts and Other Requirements.* Expenditures related to federal and state grants and contracts are subject to adjustment based upon review by the granting agencies. The amounts, if any, of expenditures that may be disallowed by the granting agencies and the resultant impact on government grants and contract revenue as well as facilities and administrative cost recovery cannot be determined at this time, although management

expects they will not have a significant effect on Vanderbilt's consolidated financial position.

(G) *Health Care Services.* Revenue from health care services includes amounts paid under reimbursement agreements with certain third-party payors and is subject to examination and retroactive adjustments. Any differences between estimated year-end settlements and actual final settlements are reported in the year final settlements are known. Substantially all final settlements have been determined through the year ended June 30, 2010. Final settlements relative to periods through June 30, 2011, are expected to be complete during fiscal 2014.

(H) *HIPAA Compliance.* Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government has authority to complete fraud and abuse investigations. HIPAA has established substantial fines and penalties for offenders. Vanderbilt maintains policies, procedures, and organizational structures to enforce and monitor compliance with HIPAA, as well as other applicable local, state and federal statutes and regulations.

(I) *Partnership Investment Commitments.* There were $555.3 million of commitments to venture capital, real estate, and private equity investments as of June 30, 2013. These funds may be drawn down over the next several years upon request by the general partners. Vanderbilt expects to finance these commitments with available cash and expected proceeds from the sales of securities. In addition, Vanderbilt is a secondary guarantor for $21.8 million of commitments for certain investment vehicles where minority limited partners in subsidiaries that Vanderbilt controls have the primary obligations.

Attachment C.Contribution to the Orderly Development of Healthcare.7.d

Licensure Certification & Plan of Correction

The Joint Commission

April 27, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Advanced Primary Stroke Center
Certification Activity: 45-day Evidence of
Standards Compliance
Certification Activity Completed: 04/27/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the certification process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the certification process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning March 14, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your certification decision.

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's certification decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

April 20, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs, CEO
Vanderbilt University Hospital and The Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Advanced Ventricular Assist Device
Certification Activity: Initial Full Event
Certification Activity Completed: 04/20/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the certification process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the certification process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning April 21, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your certification decision.

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's certification decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

October 17, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs, CEO
Vanderbilt University Hospital and The Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 10/05/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning July 24, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

November 15, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 11/09/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 28, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

November 15, 2012

Re: # 7892
CCN: #440039
Program: Hospital
Accreditation Expiration Date: July 28, 2015

Wright Pinson
Deputy Vice Chancellor for Health Affairs, CEO
Vanderbilt University Hospital and The Vanderbilt Clinic
AA 1204 MCN, 1161 21st Ave. S.
Nashville, Tennessee 37232-2101

Dear Dr. Pinson:

This letter confirms that your July 23, 2012 - July 27, 2012 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on September 28, 2012, October 05, 2012, October 23, 2012 and November 02, 2012 and the successful on-site Medicare Deficiency Follow-up event conducted on September 06, 2012, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 28, 2012. We congratulate you on your effective resolution of these deficiencies.

§482.12 Condition of Participation: Governing Body
§482.41 Condition of Participation: Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective July 28, 2012. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Hemodialysis Clinic East
20 Rachel Drive, Nashville, TN, 37214

Patterson Medical Clinic
1020 South Main Street. Ste B, Franklin, KY, 42134

Sleep Lab
Marriott @ Vanderbilt, 2555 West End Ave, Nashville, TN, 37203

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt at One Hundred Oaks
719 Thompson Lane, Nashville, TN, 37204

Vanderbilt Bone & Joint Surgery Center
225 Bedford Way, Franklin, TN, 37064

Vanderbilt Bone & Joint Clinic
206 Bedford Way, Franklin, TN, 37064

Vanderbilt Brentwood Primary Care Clinic
343 Franklin Road Suite 101, Brentwood, TN, 37027

Vanderbilt Center for Women's Imaging
3319 West End Avenue - Suite 650, Nashville, TN, 37203

Vanderbilt Eye Institute - Lebanon
1670 West Main St., Suite #100, Lebanon, TN, 37087

Vanderbilt Eye Institute - Murfreesboro
1821 Heritage Park Plaza, Murfreesboro, TN, 37129

Vanderbilt Eye Institute at Bellevue
7640 Highway 70 South, Suite 100, Nashville, TN, 37221

Vanderbilt Eye Institute at Franklin
100 Covey Drive, Suite 107, Franklin, TN, 37067

Vanderbilt Franklin Women's Center
4155 Carothers Parkway, Franklin, TN, 37067

Vanderbilt Heart - Pulaski
1265 College St., Suite 2-A, Pulaski, TN, 38478

Vanderbilt Heart at Murfreesboro
1370 Gateway Blvd. Suite 210, Murfreesboro, TN, 37129

Vanderbilt Heart at Williamson Medical Center
4323 Carothers Parkway; 405, Franklin, TN, 37067

Vanderbilt Heart at Winchester
1397 South College Street, Suite 1, Winchester, TN, 37398

Vanderbilt Ingram Cancer Center - Green Hills
3810 Bedford Ave., Suite 100, Nashville, TN, 37215

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt Medical Group - Westhaven
1025 Westhaven Boulevard, Franklin, TN, 37064

Vanderbilt Medical Group at Clarksville
647 Dunlap Lane, Clarksville, TN, 37040

Vanderbilt Medical Group at Columbia
1220 Trotwood Ave., Columbia, TN, 38401

Vanderbilt Medical Group at Coolsprings Blvd.
324 Coolsprings Blvd., Franklin, TN, 37064

Vanderbilt Medical Group at Green Hills
2002 Richards Jones Road Suite B-300, Nashville, TN, 37215

Vanderbilt Medical Group at Green Hills Village Way
3841 Green Hills Village Way, Nashville, TN, 37215

Vanderbilt Medical Group at Lebanon
1420 Baddour Parkway, Lebanon, TN, 37087

Vanderbilt Medical Group at Shelbyville
200 Dover St., Shelbyville, TN, 37160

Vanderbilt Medical Group at Springhill
3098 Campbell Station Parkway, Spring Hill, TN, 37174

Vanderbilt Medical Group at West End Ave.
2611 West End Ave., Nashville, TN, 37203

Vanderbilt Orthopedics - Wilson County
5002 Crossings Circle, Suite 230, Mount Juliet, TN, 37122

Vanderbilt Rheumatology Clinic
2001 Mallory Lane, Suite 100, Franklin, TN, 37067

Vanderbilt Sleep Disorders Center - Franklin
650 Bakers Bridge Avenue, Franklin, TN, 37067

Vanderbilt University Hospital and The Vanderbilt Clinic
1211 21st Avenue South, Nashville, TN, 37232-2101

Vanderbilt Williamson County Clinics at Coolsprings
2009 Mallory Lane, Franklin, TN, 37067

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt Williamson County Clinics at Edward Curd Lane
2105 Edward Curd Lane, Franklin, TN, 37067

Vanderbilt Williamson County Clinics at the Brentwood Shoppe
782 Old Hickory Blvd., Brentwood, TN, 37027

Vanderbilt Williamson County Clinics at the Walk-in
919 Murfreesboro Road, Franklin, TN, 37067

Vanderbilt-Ingram Cancer Center at Northcrest
500 Northcrest Drive, Suite 521, Springfield, TN, 37172

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Dozier, Cheryl A

From: Cha, Ellen <ECha@jointcommission.org>
Sent: Monday, September 24, 2012 9:46 AM
To: Conatser, Paige; Hofstetter, Patricia; Dozier, Cheryl A
Subject: Emailing: Report

Good Morning,

Here is the ESC 45.

Thank you,

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 9/22/2012

HAP Standard EC.02.03.01 The hospital manages fire risks.

Findings: EP 1 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in the elevator penthouse of the Children Hospital, the cover panel was not installed on a high voltage bus power supply and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in the B 405 mechanical room of the VUH building, high voltage wires were exposed in an electrical junction box which did not have a cover plated installed and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in electrical room # 2204 of the VUH building, high voltage wires were exposed in an electrical junction box which did not have a cover plated installed and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed on the 1st floor CCT elevator lobby, above the ceiling, high voltage wires were exposed in an electrical box with the cover door opened and therefore did not minimize the potential for harm from fire and smoke.

Elements of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.

Scoring Category: CCorrective Action Taken:
WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Installed cover panel on high voltage bus power supply in elevator penthouse of Children's Hospital. 2. Installed cover plate on open junction box in VUH building mechanical room B405 and electrical room #2204. 3. Installed cover door on open electrical box above ceiling of 1st floor CCT elevator lobby.

WHEN:

7/27/2012

HOW:

1. The Children's Hospital elevator penthouse controller cover was replaced by the elevator service company technician. 2. A work order (#591963) was completed by the Electric Shop staff for the VUH and CCT locations referenced. 3. Reviewed the standardized process for above ceiling permit program. Work was completed by certified staff.

HAP Standard EC.02.03.05 **The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.**

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park,

Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm # 1 located in the VUH generator room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm # 1 located in the VUH generator room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being testing in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm # 2 located in the VUH generator room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm # 2 located in the VUH generator room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being testing in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 A listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 A being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 B listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 B being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 mens/ladies rest room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 mens/ladies rest room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor

that at time of survey the hospital did not have an accurate inventory of all fire alarm devices.

Elements of Performance:

4. Every 12 months, the hospital tests visual and audible fire alarms, including speakers. The completion date of the tests is documented. Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Scoring Category: CCorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Added audio visual alarm #1 and alarm #2 located in the VUH generator room, VUH Room 4148A, VUH Room 4148B, and VUH Room 4148 Men's/Ladies Restroom into the device inventory. 2. Added the identified devices to the Preventive Maintenance (PM) System and performed PM on the devices. 3. Verified inventory of all audio visual alarm devices located VUH Generator Room. 4. Conducted audit of inventory of audio visual alarms for accuracy by consultant. 5. Developed standard operating process "VUMC policy for Modifications to any VUMC Fire Alarm System" to assure inventory accuracy.

WHEN:

8/1/12 added audio alarm #1 and #2 in cited areas 8/1/12 verified inventory of all audio visual alarm devices located in VUH Generator Room 8/4/12 added identified devices to the PM System and performed PM on devices 9/20/12 completed inventory of audio visual alarms 9/20/12 developed SOP

HOW:

1 & 2. Missing inventory items were field verified for location and device information and accurately entered into microprocessor based work management system with associated PM performed under Work Order 376339. 3. The devices were scheduled for their annual PM check. Process established to audit PM record compliance of audio visual alarm devices. 4. Vanderbilt employed a third party to perform a room by room inventory of observed Life Safety Equipment. That information was compared to the existing inventory database with any missing items added. 5. Established process for periodic random sampling by 3rd party to verify inventory accuracy.

HAP Standard EC.02.05.05 **The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.**

Findings: EP 3 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the hospital did not test and maintain the medical gas system. The hospital's plant operations director informed the life safety surveyor and the team leader surveyor that the hospital conducts all inspection and maintenance actives in house with the exception of the medical gas master alarm panels, and uses the manufactures inspection and maintenance recommendations for the medical gas system components. . At time of survey the hospital did not have the manufactures recommendations for inspections and testing of any of the medical gas system components, and therefore the testing and maintenance activities could not be verified at time of survey. At time of survey the hospital also did not have the vendor's inspection and maintenance documentation of the alarms on the medical gas master alarm panels and at time of survey the testing and maintenance of the alarms on the medical gas master alarm panels also could not be verified.

Elements of Performance:

3. The hospital inspects, tests, and maintains the following: Life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Reviewed recommended maintenance activities from original equipment manufacturers. 2. Confirmed PM documentation is current and accurate. 3. Engaged a third party to evaluate the operations and maintenance of the medical gas system.

WHEN:

9/20/12

HOW:

1. Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for alarm panels, zone valves, MG outlets, etc. were in place and current. 2. VUMC employed third party to verify the inventory of all MG components and develop updated facility drawings of the medical gas distribution system. 3. Engaged a third party to evaluate the operations and maintenance of the medical gas system. 4. Established a process for unannounced quarterly review by third party consultant to provide on-going verification of processes and procedures.

HAP Standard EC.02.05.07 **The hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.**

Findings: EP 5 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the PHV generator did not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during all test in EC.02.05.07, EP 4 . It was observed that the hospital did not conduct a load bank test on the PHV generator every 12 months. The load bank test was conducted on April 4, 2011 and not again until June 15, 2012. EP 6 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the hospital did not document twelve times a year, at intervals of not less than 20 days and not more than 40 days, the testing of all automatic transfer switches. Transfer switches 0201, 1000, 1001, and 1002 were documented as being tested on Nov. 3, 2011 and not again until Jan 5, 2012.

Elements of Performance:

5. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturerâ€™s recommended prime moversâ€™ exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 4, then it must test each emergency generator once every 12 months using supplemental (dynamic or static) loads of 25% of nameplate rating for 30 minutes, followed by 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 2 continuous hours.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Utilities and Construction for Medical Center Plant Services

WHAT:

Modified PM process for this particular generator test.

WHEN:

8/10/2012

HOW:

1. The preventive maintenance procedure for the load bank testing of the PHV generator was modified to provide a unique preventive maintenance task for the load bank test that includes the appropriate specifications. The new

PM task description lists the TJC standard number and the testing requirements. 2. Process established for review of the annual Preventive Maintenance records to verify compliance with standard and standardized testing procedure.

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Utilities and Construction for Medical Center Plant Services

WHAT:

1. Staff who performed the PM activity in question verified that the ATS equipment was properly tested. 2.Generator load records for December 2011 verified that the ATS equipment had been exercised. 3. Reviewed a comprehensive 12 month history of these maintenance activities to verify that individual equipment check off wasn't required and was performed consistently. 4. In May of 2012, Medical Center Plant Services Preventative Maintenance Policy #15, was revised to improve our documentation process.

WHEN:

8/10/12

HOW:

1. Plant Services Electric Shop staff was interviewed about the December 2011 ATS testing to verify that the testing took place per the maintenance tasks on the PM ticket. The staff member who did the testing signed an attestation that the ATS testing was compliant. 2. Generator load testing was reviewed to verify that the ATS equipment had been properly tested. Load test data shows conclusively that all the ATS equipment had been tested. 3. Established process for review of monthly preventive maintenance records on a monthly basis to verify compliance with standard testing requirements. 4. Plant Services revised its Medical Center Plant Services Preventative Maintenance Policy #15 to require "check boxes" be used to document completion of each task on the PM Work Order. Prior policy did not require each box to be individually checked.

HAP Standard EC.02.05.09 **The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements**

Findings: EP 1 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review it was observed that the hospital did not test, inspect and maintain the medical gas system in time frames defined by the hospital. During the document review it was observed that the hospital did not have documentation of any of the alarms on any Medical Gas Master Alarm panels being tested and inspected and maintained. The hospital informed the life safety surveyor and the team leader surveyor that the testing and inspection of the Medical Gas Master alarms were conducted by the manufacture and at time of survey the hospital did not have any documentation of the alarms on the Master Alarm Panels being tested and maintained. The master alarms panels were not on the utilities equipment inventory. At time of survey the plant operation director told the life safety survey and the team leader surveyor that the testing and inspection of the medical gas system for the last 2 inspection were only 65 % complete. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour, document review and staff discussion it was observed that the hospital did not maintain the medical gas system. It was observed that at time of survey the audio alarm on the medical gas area alarm panel located on the 4th floor NICU of the VUH was not working properly and a low oxygen alarm light and read out was showing on the panel. At time of survey the nurse manager and other staff on the unit was not aware of the alarm. The plant operations director informed the life safety surveyor and the team leader surveyor that the special equipment repair shop identified that this panel was not working properly on May 10, 2012. At time of survey the hospital received a quote from the vendor to replace the panel. EP 3 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity in the Oral Surgery Clinic, it was observed that the area shutoff valve for piped medical gas did not identify what the valve controlled. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed that the medical gas zone shut off valve located outside the kitchen in the Children Hospital was not properly labeled. During the building tour it was observed that the medical gas zone shut off valve located in the PACU of the VUH was not properly labeled.

Elements of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

The response below address both observations: 1. Master medical gas alarm panels were located in the existing preventive maintenance equipment inventory. Master medical gas alarm panels have a detailed preventive maintenance history documented. Reviewed recommended master alarm panel maintenance activities from original

equipment manufacturers and confirmed PM documentation is current and accurate. 2.Communicated with clinical staff that medical gas area alarm panel on the 4th floor VUH NICU was not working properly. 3. Scheduled and replaced 4th floor VUH NICU panel. 4. Engaged a third party to evaluate the entire medical gas system to include inspection, testing and maintenance activities. 5. Developed Policy SA 10-10.05 Life Safety Systems Area Medical Gas Alarm Panels.

WHEN:

7/25/12 communicated medical gas alarm panel not working properly 7/28/12 scheduled and replaced 4th floor VUH NICU medical gas panel 7/30/2012 located Master medical gas alarm panel on existing inventory 8/3/12 confirmed PM documentation is current and accurate 8/20/12 Developed Policy SA 10-10.05 Life Safety Systems Area Medical Gas Alarm Panels 8/23/12 3rd party evaluated entire medical gas system

HOW:

The response below address both observations: 1.Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for medical gas master alarm panels were in place and current. Master medical gas alarm panels were located in the existing preventive maintenance equipment inventory and their associated item descriptions were clarified. Master medical gas alarm panels had an existing detailed preventive maintenance history documented. 2. Posted notification signs and verbally communicated to the clinical staff, face to face, the status of the medical gas area alarm panel in the VUH NICU. 3. The panel was replaced and the new panel recertified immediately after it was installed. 4. Engaged third party to evaluate the operation and inspection, testing and maintenance of the medical gas system. 5. Established a process for unannounced quarterly review by third party consultant to provide on-going verification of processes and procedures. 6. Developed, approved, and implemented Policy SA 10-10.05 Life Safety Systems-Area Medical Gas Alarm Panels; this policy addresses communication process to clinical staff.

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

Properly labeled referenced medical gas shutoff valves.

WHEN:

7/27/2012

HOW:

A Work Order was generated in the Plant Services work management system and assigned to Plumbing Shop staff who labeled the referenced medical gas shutoff valves.

HAP Standard HR.01.06.01 Staff are competent to perform their responsibilities.

Findings: EP 15 Observed in HR File Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. Documentation in HR record for a facility management (SER) employee revealed a "Job Skill Assessment" dated 7/14/2010 stating the employee "needs training" under the topics of resetting Honeywell Fire System; resetting Simplex Fire System; and medical gas. The employee was certified as a Level 1 alarm technician in January 2011. There was no evidence of documentation for action taken for education/training and re-evaluation of competence for these areas July 2010 through January 2011.

Elements of Performance:

15. The hospital takes action when a staff memberâ€™s competence does not meet expectations.

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the approved corrective action and ongoing compliance or procedure - Directors of Plant Services; Assistant Vice Chancellor for Facilities and Construction, Manager of Human Resources Training - HR manager

WHAT:

Plant Services leadership re-educated to the required contents for employee files, and documentation of actions taken for education/training and re-evaluation of competence. Audit completed of employee files to verify SER annual job skill assessments were completed for 2012 including the specific employee observed in this finding. The additional training identified in the observation was completed and documentation was placed in the employee file. Plant Services managers enhanced the documentation of new SER employees competency through an end of probation checklist completed by the supervisor.

WHEN:

-August 8, 2012 Plant Services leadership training occurred. -August 23, 2012 employee files were audited and verified to include 2012 skills assessments. -August 29, 2012 Plant Services created end of probation competency checklist.

HOW:

HR manager conducted training during a meeting with Plant Services Department leadership to review required content for employee files and competency documentation. Plant Services Department leadership created and implemented end of probation competency checklist to be used through observation or direct interaction for Plant Services staff. Plant Services leadership established a process to conduct annual skills training and document annual ongoing competency using a skills assessment document for Plant Services staff.

HAP Standard LS.01.01.01 The hospital designs and manages the physical environment to comply with the Life Safety Code.

Findings: EP 2 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. It was observed in the basement mechanical room of the VUH building, the life safety drawing identified a fire door at the exit stair that had been removed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. The life safety drawings identified a fire door located on the 1st floor near room 1302 and the fire door had been removed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. The life safety drawings identified a fire wall in the 2nd floor mechanical room with no door. A door was installed in the fire wall and the door fire rating could not be verified.

Elements of Performance:

2. The hospital maintains a current electronic Statement of Conditions (E-SOC). Note: The E-SOC is available to each hospital through The Joint Commission Connectâ„¢ extranet site.

Scoring Category: ACorrective Action Taken: 142

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

1.Ordered and installed replacement fire doors for the basement mechanical room exit stair and 2nd floor mechanical room locations referenced. 2.Investigated history of door frame on the 1st floor near room 1302 and determined the Life Safety Code drawings were incorrect. Accordingly, revised the Life Safety Code drawings to reflect the correct condition.

WHEN:

8/8/12 installed replacement doors in cited areas 8/18/12 revised Life Safety Code drawings to reflect the corrected condition

HOW:

1. A work order was generated in the Plant Services work management system and assigned to Carpentry Shop staff who installed new fire rated doors for the basement and 2nd floor locations referenced. 2. The construction project punch list process will be used to verify missing doors are identified and installed. 3. Hospital engaged a 3rd party who reviewed and produced a new set of Life Safety Drawings. For future projects, a process was established to review the final documents with construction personnel and Plant Services personnel to verify Life Safety Drawings are accurately reflected. The deliverables required by the architect will include an updated life safety drawing.

HAP Standard LS.01.02.01 The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.

Findings: EP 2 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour of the Medical Center North building, it was observed on the 6th floor that an exit was removed and a temporary wall was installed due to the S 6400 renovation project and at time of survey there was not signage identifying the location of alternative exits to everyone affected. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During an individual patient tracer in the Children's Hospital in the GI Lab area, it was observed that there was a temporary wall in place and the egress signage still indicated that this had been an exit. There were no alternative signage observed.

Elements of Performance:

2. The hospital posts signage identifying the location of alternative exits to everyone affected. (See also LS.01.01.01, EP 3)

Scoring Category: ACorrective Action Taken: 143

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services; Construction Coordinator

WHAT:

For both the Medical Center North and Children's Hospital locations referenced, installed exit signs and signage identifying the location of alternate exits for associated areas.

WHEN:

7/27/2012

HOW:

1.A Work Order was generated in the Plant Services work management system and assigned to the Electric Shop staff who installed additional Exit signs. 2. The Construction Coordinator installed signage identifying the location and route to alternate exits. 3. The Construction Coordinator conducts Risk Assessments and identifies egress requirements.

HAP Standard NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment, and services.

Findings: EP 2 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity in the Dialysis clinic, it was noted that blood specimen containers were being labeled prior to the patient's receiving care. Individual bags of pre-labeled blood collection tubes were available on the counter. Observed in Tracer Activities at Hemodialysis Clinic East (20 Rachel Drive, Nashville, TN) site. During tracer activity in the Dialysis clinic, it was noted that blood specimen containers were being labeled prior to the patient's receiving care. Individual bags of pre-labeled blood collection tubes were located in a basket on the counter.

Elements of Performance:

2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Associate VMG Director, Clinical Manager. Responsible for approved action or procedure: Associate VMG Director, Area Manager.

WHAT:

The pre-labeling process was immediately changed by the Clinical Managers of the VAV Dialysis Clinic and

Hemodialysis Clinic East, via informal clinical staff training. Formal training completed with emphasis on patient identification and labeling, VUMC processes for collecting blood specimens, and Policy CL 30-08.22 "Labeling of Laboratory Specimens": "Containers used for blood and other specimens are labeled in the presence of the patient."

WHEN:

July 26 and 27, 2012: Immediate training and process change completed. August 21, 2012: Formal training completed in the Village at Vanderbilt Dialysis Clinic: and the Hemodialysis Clinic East.

HOW:

The Clinic Manager immediately discarded all pre-labeled blood collection tubes and verbally instructed staff on the process change. An educational presentation regarding the current policy CL 30-08.22 "Labeling Laboratory Specimens" was presented and distributed to the dialysis clinical staff for review.

HAP Standard NPSG.03.04.01 **Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.**

Findings: EP 2 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity at the Plastics clinic a procedure room was made ready for excision and closure of facial lesions. The mayo stand had been prepared with the sterile instruments and the small empty metal cups and empty syringe were found labeled. The patient had not yet arrived for the procedure. A review of the hospital policy revealed, "Label medication container/storage device when any medication in transferred from the original packaging to another container/storage device and is not immediately administered." Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During an individual patient tracer in the Children's Hospital operating room, it was observed that the sterile field had a basin with a label, but there had not been any transfer of fluids or medications. The organizational policy, Cl30-06-21, requires that the label would be completed at the time of transfer if not immediately administered.

Elements of Performance:

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Administrative Director, Clinical Managers.
Responsible for approved action or procedure:

Administrative Director.

WHAT:

Clinical staff were educated on VUMC process and policy CL 30-06.21 "Medication Labeling: Outside of Pharmacy." Policy states "Label medication/solution package/container/ storage device when any medication is transferred from the original packaging to another package/ container/storage device and is not immediately administered. Label medication/solution package/ container/storage device as soon as it is prepared, unless it is immediately administered."

WHEN:

August 17, 2012: Plastic Surgery Clinic staff training completed. July 31, 2012 and August 13, 2012: Children's Operating Room staff training completed.

HOW:

Inservice training were completed, an educational memo regarding the current policy CL 30-06.21 "Medication Labeling: Outside of Pharmacy" was electronically distributed to the clinical staff.

HAP Standard PC.01.02.07 The hospital assesses and manages the patient's pain.

Findings: EP 3 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The post operative patient reported on July 25 a pain level of 8 at 01:20, a pain level of 7 at 04:05, and a pain level of 8 at 07:49. The patient was medicated at each of those times. There was no documentation of interventions and the effectiveness of them between 01:20 and 04:05 and 07:49. A physician order for an additional medication for pain was obtained at 06:00. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. On July 23 patient was medicated for pain level of five .The next assessment of response to the pain management intervention was at 3:30 on July 24,and pain level was five.There was no documentation of further interventions or the effectiveness of pain management between 17:30, July 23 and 3:30, July 24 ,2012.

Elements of Performance:

3. The hospital reassesses and responds to the patientâ€™s pain, based on its reassessment criteria.

Scoring Category: CCorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Nurse Managers of 8N and 7T3; Administrative Director for Medicine and Administrative Director for Surgery/Burn; Chief Nursing Officer VUH. Responsible for approved action or procedure: Nurse Managers of VUH 7T3 and Manager of VUH 8th floor; Administrative Director for Medicine and Administrator

Director for Surgery/Burn; Chief Nursing Officer VUH.
Training:All RNs on VUH 7T3 and VUH 8 North.
Responsible for Measure of Success: Nurse Managers of VUH 7T3 and Manager of VUH 8N; Administrative Director for Medicine and Administrator Director for Surgery/Burn.

WHAT:

Applicable clinical staff were educated on VUMC process and policy CL 30-02.04 "Pain Management Guidelines" section V.A.3. The policy states "In Inpatient areas, document the following with date and time:Reassessment of pain response to interventions is documented at an interval based on patient condition and type and route of pharmacologic intervention."

WHEN:

8/23/12: Corrective action plan presented to the Vanderbilt University Hospital Nursing Leadership Board.
9/20/2012: training completed.

HOW:

Electronic learning module developed and assigned to clinical staff on 8N and 7T3.

Evaluation Method: Medical record review is the selected method to evaluate the effectiveness of the corrective actions. A computer generated random sample of 70 random patient medical records with pain from units 7T3 and 8N will be reviewed monthly for reassessment of pain after medication. Title of person collecting data: Nurse manager and Administrative director of the two units. Numerator= # of reassessment after pain medication Denominator= # of pain medications administered to 70 patients with pain Frequency = Monthly Duration 4 consecutive months

Measure of Success Goal (%): 90

Dozier, Cheryl A

From: Cha, Ellen <ECha@jointcommission.org>
ent: Wednesday, September 26, 2012 2:04 PM
To: Conatser, Paige; Hofstetter, Patricia; Dozier, Cheryl A
Subject: Emailing: Report

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 10/7/2012

BHC	**Standard CTS.02.01.05**	**For organizations providing care, treatment, or services in nonâ€"24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination. Note 1: This standard does not apply to foster care and therapeutic foster care. (See also CTS.02.04.01, EP 1) Note 2: This standard does not apply to organizations that provide physical examinations to all individuals served as a matter of policy or to comply with law and regulation.**

Findings: EP 1 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The organization has implemented a health screening process. However, in reviewing that process, and in reviewing policy and procedure, they have not established screening triggers that indicate the need for a medical history and physical examination.

Elements of Performance:

1. For organizations providing care, treatment, or services in nonâ€"24-hour settings: The organization has a written physical health screening process to determine whether an individual served is in need of a medical history and physical examination that is based on the population(s) served and, at a minimum, includes the following: - Data to be collected - Time frame for completion of the screening - Screening triggers that indicate the need for a medical history and physical examination

Scoring Category: ACorrective Action Taken:

WHO:

Director of Social Work and Partial Hospitalization Program (PHP); Chief Medical Officer (PHP) Trained: PHP staff

WHAT:

1.Health Screening revised. 2.Staff educated. 3.The revised tool was implemented.

WHEN:

September 1, 2012: Staff educated and health screening tool implemented.

HOW:

1. Health Screening revised in collaboration with the Chief Medical Officer for the addition of triggers that indicate a need for a Physical Examination. 2. Staff educated on the revised tool at staff meeting. 3. The revised tool was implemented.

BHC Standard CTS.03.01.03 The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Findings: EP 3 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format included a goal and interventions but did not have objectives. Objectives for each goal should be developed and should be expressed in terms that provide indices of progress. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format did not include objectives. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format did not include objectives.

Elements of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress

Scoring Category: CCorrective Action Taken:

WHO:

Director of Social Work and Partial Hospitalization Program (PHP) Trained: Staff (PHP)

WHAT:

"Objectives" added to the treatment plan and staff educated.

WHEN:

August 23, 2012: All PHP staff trained. September 1, 2012: Revised treatment plan was implemented.

HOW:

August 23, 2012: Staff trained at staff meeting to quantify objectives on the treatment plan. September 1, 2012: The revised treatment plan was implemented.

Evaluation Method: All patient treatment plans audited for evidence of compliance monthly for four consecutive months. Audit patient treatment plans

objectives for evidence of compliance.
Numerator= # correct treatment plans
Denominator = total number of treatment plans

Measure of Success Goal (%): 90

HAP Standard EC.02.05.01 The hospital manages risks associated with its utility systems.

Findings: EP 1 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review , building tour and staff discussion it was observed that the hospital did not design and install utility systems that meet patient care and operational needs. It was observed during the building tour, that a field fire alarm panel located in a mechanical room on the 4th floor of the VUH was in alarm, and at the front head end master fire alarm computer no alarm was identified. The plant operations director informed the life safety surveyor and the team leader due to the age of the fire alarm panels and the additions and modifications of the fire alarm system that the front head end master fire alarm computer can clear an alarm but a technician must physically go to the field fire alarm panel to clear the alarm from that panel. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review , building tour and staff discussion it was observed that the hospital did not design and install utility systems that meet patient care and operational needs. It was observed during the building tour, that a field fire alarm panel located in the delta center has 6 fire alarm light in alarm, and at the front head end master fire alarm computer shows these alarms as 46 troubles. The plant operations director informed the life safety surveyor and the team leader due to the age of the fire alarm panels and the additions and modifications of the fire alarm system that the front head end master fire alarm panel identifies these as troubles. At time of survey the hospital could not identify which of the 46 troubles were associated with the 6 alarms on the field panel. EP 4 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review it was observed that the hospital did not identify, in writing, inspection and maintenance activities for all operating components of utility systems on the inventory. The hospital's plant operations director informed the life safety surveyor and the team leader surveyor that the hospital uses the manufactures inspection and maintenance recommendations on all operating components of the utilities system listed in their equipment inventory. At time of survey the hospital did not have the manufacture written recommendations for the inspection and maintenance of all operating components of the utilities system listed in their equipment inventory. At time of survey the hospital did not have the manufactures recommendations for inspections and testing of any of the air handler unit, domestic hot water pumps, generator fuel pumps, air compressors or any of the medical gas system components. EP 8 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour of the VUH it was observed that the hospital did not label the following utility system controls to facilitate partial or complete emergency shutdowns: Generator fuel pumps # 1 and # 2 located in the generator mechanical room; the air compressor located in the generator room; Generators 1 though 5; Hot water primary pump # 1 and back up pump # 2 located in mechanical room B405; AHU 11; AHU 12; AHU 14; AHU 22.

Elements of Performance:

1. The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Reviewed Honeywell documentation of features requiring manual acknowledgment of each alarm at the local panel. 2. Acknowledging all alarm conditions on the field fire alarm panels as they occur 3. Reviewed Honeywell's letter to verify alarm panel requirements. 4. Honeywell reprogrammed panels to accept return to normal acknowledgment from the front end system.

WHEN:

8/3/12: reviewed Honeywell documentation 8/3/2012: process established to acknowledge alarms 8/4/2012: Reviewed Honeywell letter 9/28/2012: reprogrammed panels

HOW:

1. Established a process to acknowledge all alarm conditions on the field fire alarm panels as they occur. 2. Honeywell reprogrammed panels to accept pt return to normal acknowledgment from the front end system.

4. The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Located and reviewed the Operation & Maintenance (O&M) manuals from original equipment manufacturers for referenced equipment. 2. Confirmed PM documentation is current and accurate.

WHEN:

8/27/2012

HOW:

1. Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for air handler units, domestic hot water pumps, generator fuel pumps, air compressors and all medical gas system components were in place and current. 2. Confirmed work management system

inspection and testing PM documentation is current and accurate for all referenced equipment.

8. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

Need to address labeling of these items to facilitate shutdown. 1. Developed Shutdown procedures and labeled controls as appropriate.

WHEN:

8/27/2012

HOW:

(Need to address labeling of these items to facilitate shutdown.) 1. The Plant Services Team met with VUMC senior leadership, wrote and implemented shutdown procedures and labeled controls as appropriate. 2. Plant Services staff was trained on steps to apply the Shutdown procedure

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HAP Standard EC.03.01.01 Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Findings: EP 2 Â§482.41(b)(7) - (A-0714) - (7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed the staff working in the Subway restaurant could not describe or demonstrate actions to take in the event of an environment of care incident. The manager of the Subway restaurant said neither her or her staff had been educated to the hospitals safety programs including fire safety. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed the staff working in the Taco Bell / Pizza Hut restaurant could not describe or demonstrate actions to take in the event of an environment of care incident. The manager of the Taco Bell/ Pizza Hut restaurant said neither her or her staff have been educated to the hospitals safety programs including fire safety. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed in the emergency room fast track area that the charge nurse and the manager of the unit did not know where the medical gas zone shut off valves were and could not find them for the fast track rooms 1343A and 1343B. In the event of a fire the hospital policy states that the charge nurse is responsible for shutting off the medical gases.

Elements of Performance:

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also EC.02.03.01, EP 10 and HR.01.04.01, EP 1)

Scoring Category: CCorrective Action Taken:

WHO:

Director, Retail VUMC, Patient Transportation Support Services Administration; Director of Environmental Health and Safety; Asst. Director/ Vanderbilt Environmental Health and Safety Who was trained: staff of the identified vendors; charge nurses and the manager of the ED Responsible for Measurement: The Asst. Director Vanderbilt Environmental Health and Safety

WHAT:

1.Developed and Implemented an enhanced safety education plan to include the process to follow in fire safety and emergency prepareness incident for the identified vendor employees in the vendor areas of the hospital. Education includes onboarding vendors and vendor new hires through VUMC new staff orientation. 2. Developed and implemented policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels. 3. Developed and implemented an enhanced safety education plan for managers and charge nurses regarding medical gas processes to follow in the event of an environment of care incident. 4. Modified annual safety training to include medical gas safety components.

WHEN:

8/9/12: vendor education plan 8/20/12: policy approved/implemented 8/22/12: Staff education plan for medical gases

HOW:

1. Designed a vendor education plan to train identified vendor employees in the steps needed to take in the event of a fire safety and emergency prepareness incident. The Environment of Care Safety module was deployed to identified vendor employees; instruction was lead by the unit leader. Education includes onboarding vendors and vendor new hires through VUMC new staff orientation. 2.The Medical Gas Alarm Panel Policy was developed by VUMC senior leaders and Plant Services; approved by the Medical Center Medical Board. 3. Designed a staff education plan to train managers and charge nurses in the ED Fast Track regarding medical gases and the steps needed to take in the event of an environment of care incident for patient and staff safety. The Medical Gas module was distributed electronically to identified managers, area supervisors and charge nurses. 4. Annual Safety training is electronically accessed by staff.

Evaluation Method: There will be monthly monitoring for 4 consecutive months of the identified random

vendor employees fire safety and emergency prepareness knowledge ; Numerator: compliant vendor employees. Denominator: 30 identified vendor employees. There will be monthly monitoring for 4 consecutive months of ED Charge nurses and manager for medical gas panel knowledge. Numerator: compliant ED Charge nurses and managers. Denominator: all ED charge nurses and managers. The Survey results will be shared with VUMC Leadership monthly.

Measure of Success Goal (%): 90

HAP Standard LD.01.03.01 The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Findings: EP 2 Â§482.12 - (A-0043) - Â§482.12 Condition of Participation: Condition of Participation: Governing Body This Condition is NOT MET as evidenced by: Observed in Data Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. The Governing Body did not insure that the following COPs were met as determined by observation, documentation, and staff interviews. COP 482.41 Tag A-0700, Physical Environment system and notifications.

Elements of Performance:

2. The governing body provides for organization management and planning.

Scoring Category: ACorrective Action Taken:

WHO:

Chief Executive Office of Clinical Enterprise and Deputy Vice Chancellor for Health Affairs; Chief Quality and Patient Safety Officer Trained: Identified Vendor staff and identified area staff where medical gas alarm panel are located

WHAT:

1. Annual Life Safety reports and periodic updates are provided to the Medical Center Medical Board and the Governing body through established reporting structures. In addition to the established reporting structure and processes, the Chief Executive Officer of the Clinical Enterprise and Deputy Vice Chancellor for Health Affairs has expanded the reporting and accountability for the Assistant Vice Chancellor of Facilities and Construction to include direct reporting to Deputy Vice Chancellor for Health Affairs. 2. Quarterly reports are made to the Quality Steering Committee of the Vanderbilt University Medical

Center. The Quality Steering Committee, co-chaired by the Chief Executive Officer of the Clinical Enterprise and Vice Chancellor for Health Affairs and the Chief Quality and Patient Safety Officer, has the authority and responsibility to execute recommendations from the Life Safety reports. 3. The VUMC Safety Committee monthly meeting standing reports have been expanded to include additional aspects of life safety. Distributions of meeting minutes have been expanded to include senior leadership. The Environment of Care survey process has been expanded to include additional aspects of Life Safety in their ongoing rounding and audits. 4.Developed and implemented fire safety and emergency preparedness education plan for identified vendor staff. Developed and implemented an enhanced safety education plan for identified staff where medical gas alarm panels are located. 5. Policy SA 10-10:05 Life Safety Systems â€" Area Medical Gas Alarm Panels was approved by the Medical Center Medical Board and approved by senior leadership.

WHEN:

8/ 9/2012: Incorporated new/revised indicators into the Environment of Care(EOC)survey process 8/ 9/2012: Process established for EOC quarterly reports to senior leadership 8/ 15/2012: Most recent enhancements to the accountability structure 8/20/2012: Policy approved

HOW:

1. The changes in the reporting and accountability structure and quarterly Life Safety reports are incorporated into the organizational Quality Improvement work plan and the changes were fully vetted by the senior leadership team and agreed upon. 2. Senior leadership met to review the EOC process. Additional indicators were added and revised in response to the survey findings. 3. Quarterly and annual EOC summary reports continue to be reviewed by the EOC survey team and the Medical Center Safety Committee. Additionally,a process was established for EOC summary reports to be sent directly to senior leadership in the clinical enterprise. 4. The standing life safety reports to the VUMC Safety Committee includes status of required generator testing, automatic transfer switches, Fire Alarm equipment, changes to Life Safety Drawings, and penetrations. 5. A process was established for the EOC team leader to make quarterly reports to the VUH, VCH, VMG and VPH senior leadership cabinet meetings for follow-up actions. 6. The Plant Services Team met with VUMC senior leadership to design a staff education plan to train staff in areas where medical gases exist in the steps needed to take in the event of an environment of care incident. A vendor education plan was designed to train the identified vendor employees in fire safety and emergency preparedness. The plan included a design and deployment of Fire Safety and Emergency Preparedness Safety Training and a design and deployment of a staff electronic E-Learning module focused on the Medical Gases. The Emergency

preparedness vendor safety module was deployed to the identified vendor employees; instruction was led by the unit leader. The Medical Gas module was distributed electronically to VUMC managers, area supervisors and charge nurses of the identified area. 7. The Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels was approved by the Medical Center Medical Board.

HAP	**Standard LD.03.04.01**	**The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.**

Findings: EP 6 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the Life Safety Code Building Tour the Engineer identified a non-functioning audible alarm that would indicate failure of medical gases in the fourth floor Neonatal Intensive Care Unit. As a result of this finding additional tracer activities were conducted to determine preservation of patient safety in the event of a medical gas failure. From an interview with staff, including physicians, nurses and respiratory therapists, it was observed that none of the clinical staff were aware of the change in the environment produced by the non-functioning audible alarm for a failure of medical gases. The same staff members were unaware of the presence of the alarm lights indicating the non-functioning alarm. From staff interviews, document review and review of past environmental incidents it was observed that the clinical staff effectively responded to a change in the environment to preserve patient safety; however, there was no indication that that changes in the environment, including non-functioning medical gas alarms, are effectively communicated to the clinical staff.

Elements of Performance:

6. When changes in the environment occur, the hospital communicates those changes effectively.

Scoring Category: ACorrective Action Taken:

WHO:

VUH & TVC CEO; VCH CEO; Assistant Vice Chancellor for Facilities and Construction; Executive Director Vanderbilt Environmental Health and Safety

WHAT:

1. Commissioned a third party review of medical gas system operations and maintenance. 2. Developed/implemented Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels. 3. Trained NICU Stallman staff 4. Posted signs at Nursing Station and alarm panel locations. 5. Replaced NICU Med Gas Area Alarm Panel.

WHEN:

7/26/2012: signs posted in NICU 7/27/2012: NICU staff trained 7/28/2012: Replaced panel 8/16/2012: third party review commissioned 8/20/2012: policy approved

8/23/2012: All charge nurses and area managers trained

HOW:

1. Commissioned a third party review of medical gas system operations and maintenance. 2. The Medical Gas Alarm Panel Policy was approved by the Medical Center Medical Board. 3. A staff education plan was designed to train the NICU Stallman staff on medical gases and the steps to take in the event of an environment of care incident for patient and staff safety. The plan included the design and deployment of a staff electronic E-Learning Module focused on the medical gases. The medical gas module was distributed electronically to VUMC managers, area supervisors and charge nurses in NICU Stallman. 4. Posted signs at the nursing station and alarm panel locations. 5. Work order was generated in the plant services work management system and assisgned to a qualified staff who performed the work.

HAP Standard LD.04.01.05 The hospital effectively manages its programs, services, sites, or departments.

Findings: EP 4 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review and staff discussion it was observed at time of survey that leadership did not ensure that the hospital had a process in place and staff was trained to address alarms and troubles on the fire alarm system. On the 1st day of survey it was observed that the simplex fire alarm system had 26 troubles and the honeywell fire alarm system had 49 troubles. On the 1st day survey the staff monitoring the fire alarm panels and the plant operations staff and the special equipment repair shop staff could not identify the location or the nature of the troubles. Both fire alarm panels indicated the troubles have been active for over 7 days. The hospital conducts all system repairs in house and at time of survey there was no process in place to address these troubles. On day 4 of survey the simplex fire alarm panel had 15 troubles and the honeywell fire alarm system had 46 troubles. Observed in Tracer Activities at NICU at the main hospital. During tracer activities, building tour, and leadership discussion, it was established that there was not an established process to communicate issues in the Life Safety Code functions that could effect safe clinical operations. There was a low oxygen pressure alarm in the Neonatal Intensive Care Unit that the staff had not been notified or educated as to interim measures to protect the patients in that area.

Elements of Performance:

4. Staff are held accountable for their responsibilities.

Scoring Category: ACorrective Action Taken:

WHO:

VUH & TVC CEO; VCH CEO; Assistant Vice Chancellor for Facilities and Construction; Executive Director Vanderbilt Environmental Health and Safety Trained: Delta Staff, NICU Stallman staff

WHAT: 157

1. Established a Standard Operating Procedure (SOP) [Plant Services Policy 58 "Life Safety System-Trouble/Supervisory Message Response"] to identify response to trouble alarms on the fire alarm system. 2. Commissioned a third party review of fire alarm system. 3. Commission a third party review of medical gas system operations and maintenance. 4. Developed and implemented policy SA 10-10.05 Life Safety Systems - Area Medical Gas Alarm Panel. 5. Delta staff trained on SOP. 6. NICU Stallman staff trained on medical gases.

WHEN:

7/27/2012: SOP established 7/27/2012: Delta staff trained. 7//27/2012: NICU Stallman Staff Trained 8/16/2012: commissioned third party reviews 8/17/2012: completed third party review 8/20/2012: policy approved

HOW:

1. SOP approved by Assist Vice Chancellor for Facilities and Construction. 2. Completed third party review of fire alarm system operations and maintenance. 3. A staff education plan was designed to train staff in NICU Stallman on medical gases and the steps to take in the event of an environment of care incident. The plan included the design and deployment of a staff electronic E-Learning Module focused on the Medical Gases. The Medical Gas module was distributed electronically to VUMC managers, area supervisors and charge nurses of NICU Stallman. 4. The Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panel was approved by the Medical Center Medical Board. 5. The Delta Staff was provided face to face training by their manager.

HAP Standard LS.02.01.10 Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, the fire rating labels on the fire doors were damaged so that the fire rating could not be verified on the following fire

doors; Fire door # 7442, Fire door # 5442, Fire door # 4442. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that the fire rating could not be verified on the exit door located on the 4th floor S 2 center exit stair. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that the fire rating could not be verified on the fire door located on the 2nd floor N mechanical room of the VUH building. EP 9 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH building it was observed that the fire wall at exit stair # 2086, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building it was observed that the fire wall at exit stair # 02100, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children Hospital building it was observed that the fire wall at door # 8404, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed on the 4th floor at the double fire doors near TVC north elevator lobby, above the ceiling the fire wall had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the 2nd floor north mechanical room, the fire wall had a penetration that was not properly sealed.

Elements of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Removed paint from rating labels for all Medical Center North fire door locations referenced. 2. Ordered and installed replacement fire doors for the VUH locations referenced. 3. EOC survey process revised.

WHEN:

7/24/2012: removed paint 8/9/2012: revised EOC indicator 8/24/2012: installed doors

HOW:

1.A work order was generated in the Plant Services work management system and assigned to Paint Shop staff who removed paint from door rating labels for the Medical Center North fire doors referenced and to Carpentry Shop staff who installed new fire rated doors for the VUH doors referenced. 2. Revised EOC survey process to include indicator for inspection of labels on rated doors.

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category: CCorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Sealed penetrations referenced.

WHEN:

8/3/12

HOW:

1. A Work order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically sealed the penetrations referenced. 2.Implemented the above ceiling permit program for standardization of sealing penetrations. Work was completed by certified staff.

HAP Standard LS.02.01.20 The hospital maintains the integrity of the means of egress.

Findings: EP 13 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT

MET as evidenced by: Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity three C-arms were stored in the bridge joining the perioperative services with the Vanderbilt Clinic. These C-arms were obstructing the clear exit for discharge. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 5th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department pod A, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department pod A was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 6th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 7th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department pod B, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department pod B was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department fast track, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department fast track was not identified as a suite. EP 31 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH it was observed that 2 exit sign were missing on the adult wing. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the mechanical room B406, exit signs were

missing. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the mechanical room B405, exit signs were missing.

Elements of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category: CCorrective Action Taken:

WHO:

VUH & TVC CEO; Assist Vice-Chancellor for Facility Services and Construction. Assistant Director Vanderbilt Environmental Health & Safety

WHAT:

1. Removed obstructions from path of egress for all locations referenced to maintain clear corridor and clear exit. 2.Identified alternate (permanent) location for C-Arm, trash and recycle container storage and moved these items to new locations. 3.Communicated trash and recycle container storage plan with Medical School Environmental Services. 4.Established a reporting process for EOC Survey results to Hospital Leadership. 5.Communicated egress standard requirement to hospital unit managers by senior leadership.

WHEN:

8/3/12: Met with involved departments to resolve egress issues and removed obstructions 8/10/12: Established communication process to executive leadership 8/27/12: communicated egress standard requirements to managers

HOW:

1. Plant Services met with Radiology Services regarding C-arm obstructions, Environmental Services with respect to trash and recycle container obstructions, and with Directors and Managers of the VUH ED regarding egress impediments within the ED to create an action plan to resolve these issues. Alternate and permanent storage locations for C-arms and trash and recycle containers were identified that did not obstruct the clear exit for discharge or means of egress and these items were moved accordingly. ED staff removed obstructions from egress corridors within their area. 2. Established a communication process to report results of the EOC Surveys to Executive leadership quarterly. 3. Senior leadership communicated egress standard requirements via email to hospital unit managers.

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)

Scoring Category: CCorrective Action Taken:162

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Operations & Compliance for Medical Center Plant Services

WHAT:

Installed missing exit signs.

WHEN:

8/8/12

HOW:

1.The Plant Services Team met with VUMC senior leadership to design and implement the action plan below to ensure compliance with LS.02.01.20 2. A Work order was generated in the Plant Services work management system and assigned to qualified Electric Shop staff who installed the exit signs at the locations referenced. 3. The established EOC survey process monitors exit signs. The EOC survey results are shared with Executive leadership quarterly.

HAP Standard LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Findings: EP 11 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door near elevator 11 did not have positive latching hardware installed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door 1465 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door 1466 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the

corridor door 1462 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. EP 18 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH, it was observed that the smoke wall at door 1101 had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH, it was observed that the smoke wall near the CCT elevator lobby on the 1st floor, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH, it was observed in electrical closet 1364, the smoke wall had a penetration that was not properly sealed. The electrical closet did not have a ceiling and was not properly sealed to deck above.

Elements of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services. Trained: Plant Services staff

WHAT:

1. Installed positive latching for the door near elevator 11. 2. Obtained Proposal from the door manufacturer's local representative/installer for doors that include positive latching. Issued a Purchase Order accordingly and scheduled installation for completion based on anticipated receipt of materials by installer. 3.Interim Life Safety assessment performed and plan implemented. 4.Retrained plant services staff on SA 40-10.05 Interim Life Safety Implementation.

WHEN:

8/3/12: installed door near elevator 11 8/8/12: obtained

Proposal 9/21/12: new ED doors received 9/7/2012: Interim Life Safety Measure performed and plan implemented

HOW:

1. A Work Order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically installed positive latching hardware for the door near elevator 11. 2. A work Order was generated in the Plant Services work management system associated with the Proposal and issuing of a Purchase Order for the Emergency Department doors requiring positive latching. 3. Notified Emergency Room Management of the door positive latching Interim Life Safety Measure. 4.Posted interim Life Safety Measure in Emergency Room Department 5.Retrained Plant Services Staff regarding Interim Life Safety implementation Policy.

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Sealed penetrations referenced and sealed to deck in electrical closet 1364.

WHEN:

7/27/12

HOW:

1. The Plant Services Team met with VUMC senior leadership to design and implement the action plan below to ensure compliance with LS.02.01.30 EP 18 (C) evidenced by resolution of findings and maintaining and or implementing standardized, systematic processes to sustain a safe patient and staff environment evidenced by the following: 2. A Work order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically sealed the penetrations referenced. 3.Implemented the above ceiling permit program for standardization of sealing penetrations. Work was completed by certified staff.

HAP Standard LS.02.01.35 The hospital provides and maintains systems for extinguishing fires.

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of Medical Center North building it was observed near room S 5 405 cables were tied to the sprinkler piping. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of Medical Center North building it was observed near room S 5 429 cables were tied to the sprinkler piping. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of VUH building it was observed on the 2nd floor near mechanical room south, cables were tied to the sprinkler piping. EP 5 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity in the Oral Surgery Clinic, it was observed that there was an accumulation of dust on a sprinkler head located in the dirty utility room. Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity in the Hematology clinic, it was observed that there was an accumulation of dust on the sprinkler head. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the soiled utility room 4206, plastic was wrapped around the sprinkler head. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed it the kitchen, sprinkler head # 1 and # 2 was not free from foreign materials. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed it Subway's kitchen, sprinkler head # 3 and # 4 was not free from foreign materials.

Elements of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Relocated cables.

WHEN:

7/27/2012

HOW:

1. A Work order was generated in the Plant Services work management system and assigned to qualified Electric Shop staff who physically relocated the cables. 2.Implemented the above ceiling permit program for requirements related to sprinkler heads piping. Work was completed by staff with current certification.

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services; Manager of VUMC Plumbing Shop Trained: EVS staff

WHAT:

1. Cleaned sprinkler heads. 2. Trained Environmental. Services(EVS) to clean sprinkler heads.

WHEN:

8/3/12: cleaned sprinkler heads 8/8/12: trained EVS 8/9/2012: indicator added to EOC survey process

HOW:

1.A Work Order was generated in the Plant Services work management system and assigned to qualified Plumbing Shop staff who physically cleaned the sprinkler heads. 2.Trained environmental services staff for ongoing cleaning through face to face demonstration. 3.The established EOC survey process has been revised to include observation of sprinkler heads. Established communication to Executive leadership of EOC Survey Results quarterly.

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 10/28/2012

HAP **Standard LS.01.02.01** **The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.**

Findings: EP 3 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. In review of deficiencies noted from the 7/12 survey, the organization failed to assess and implement ILSM's according to the policy in place (ex. Doors found noncompliant at LS.02.01.30 EP11). This issue was immediately corrected by leadership and AFS10 is not warranted.

Elements of Performance:

3. The hospital has a written interim life safety measure (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital follows special measures to compensate for increased life safety risk. (See also LS.01.01.01, EP 3)

Scoring Category: A

('ective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director Operations & Compliance for Medical Center Plant Services; Trained: Plant Services and Space and Facilities Staff

WHAT:

1. The Identified Interim Life Safety Measures(ILSM) were created and implemented according to hospital policy SA 40-10.05, Interim Life Safety Implementation. 2. Notified the Emergency Department Clinical Management of the Interim Life Safety Measure status. 3. Posted Interim Life Safety Measure notification in Emergency Department. 4. Created and implemented a PFI due to extension of work process for installation of doors. 5. Revised the standardized process that ILSMs are implemented when a life safety issue is identified. 6. Trained Plant Services and Space and Facilities Staff on revised ILSM process.

WHEN:

9/6/12 created ILSM 9/6/12 notified ED 9/6/12 posted ILSM 9/7/12 created PFI 9/20/12 Revised ILSM process 9/20/12 trained Plant Services and Space and Facilities Staff

HOW:

1. The Plant Services leadership identified and created an ILSM to address the door safety issue. The Plant Services leadership then deployed qualified staff and implemented the ILSM process. 2. Notified the ED Clinical Management of the Interim Life Safety Measure,face to face. 3. Posted an Interim Life Safety Measure in the Emergency Department (ED). 4. Created and implemented a PFI while awaiting door installation. 5. Plant Services leadership created a reliable, standardized ILSM process which requires staff to sign off on each ILSM assessment. ILSMs are regularly reviewed by Plant Services Management to verify ILSM assessment and implementation occurs. 6. Trained Plant Services and Space and Facilities Staff regarding revised ILSM process , face to face.

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 11/12/2012

HAP Standard LS.02.01.20 The hospital maintains the integrity of the means of egress.

Findings: §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP 13 not cleared, during building tour of 7th floor noted many carts and other equipment stored in corridors. §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP 13 not cleared, during building tour of 7th floor noted many carts and other equipment stored in corridors.

Elements of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category: C

Corrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Operations & Compliance for Medical Center Plant Services; Assistant Director Vanderbilt Environmental Health & Safety; VUH & TVC COO

WHAT:

1. Removed obstructions from path of egress for all locations referenced to maintain clear corridor and clear exit. 2. Re-communicated egress standard requirement to hospital unit managers by senior leadership. 3. Communicated Environment of Care (EOC) survey results to Hospital Leadership.

WHEN:

8/ /2012: EOC process changed 9/6/12: Date obstructions cleared 10/26/12: Re-communication to managers

HOW:

1. Cleared carts and equipment from 7th Floor Roundwing corridors. 2. Senior leadership re-communicated egress standard requirements via email to hospital unit managers. 3. The EOC survey process includes monitoring of compliance with the required standard. EOC survey process changed to include reporting of survey results to Executive leadership quarterly.

HAP Standard LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Findings: §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP11 not cleared. §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP11 not cleared.

lements of Performance:

1. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are inged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no arger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps he door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, o NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

coring Category: C

orrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

1. Obtained proposal from the door manufacturer's local representative / installer for replacement doors that include positive latching. 2. Issued a Purchase Order and scheduled installation for completion based on anticipated receipt of materials by installer. 3. Notified Emergency Department management of the door positive latching Interim Life Safety Measure. 4. Posted interim Life Safety Measure in Emergency Department(ED). 5. Created and implemented a PFI while awaiting door installation. 6. Completed installation of ED doors.

WHEN:

8/7/12: Proposal received from door supplier 8/16/12: Purchase Order completed; 9/6/12: Notified Emergency Department management and posted ILSM information 9/7/12: Created PFI 10/15/12: ED doors installation completed

HOW:

1. A Work Order was generated in the Plant Services work management system associated with the proposal and issuing of a Purchase Order for the Emergency Department doors requiring positive latching. 2. Notified Emergency Department management of the door positive latching Interim Life Safety Measure, face to face. 3. Posted Interim Life Safety Measure in Emergency Department. 4. The ED doors were installed by qualified staff.

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Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - Measure of Success Form

Due Date: 2/14/2013

BHC Standard CTS.03.01.03 The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Elements of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 100
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 100
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 97
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 95
Actual Average Goal (%): 98
Optional Comments: Month 1: 36/36 = 100% Month 2: 42/42 = 100% Month 3: 33/34 = 97% Month 4: 39/41 = 95% Actual Average Goal: 150/153 = 98%

HAP Standard EC.03.01.01 Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Elements of Performance:

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also EC.02.03.01, EP 10 and HR.01.04.01, EP 1)

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 90
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 100
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 100
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 100
Actual Average Goal (%): 97
Optional Comments: Month 1: 36/40 = 90% Month 2: 42/42 = 100% Month 3: 38/38 = 100% Month 4: 39/39 = 100% Actual Average Goal: 155/159 = 97%

HAP Standard PC.01.02.07 The hospital assesses and manages the patient's pain.

Elements of Performance:

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 92
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 96
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 97
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 97
Actual Average Goal (%): 95
Optional Comments: Month 1: 315/344 Month 2: 302/316 Month 3: 315/326 Month 4: 308/319 1240/1305 = 95%

SUPPLEMENTAL-#1

-Copy-

Vanderbilt Hospital

CN1406-021

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Vanderbilt University Hospitals

I, Ginna Felts, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Ginna Felts
CONSULTANT, BUSINESS DEVELOPMENT

Sworn to and subscribed before me, a Notary Public, this the 25th day of June, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

Jennifer Hygrell
NOTARY PUBLIC

My commission expires May 5, 2015.

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

HF-0043

Revised 7/02

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

Ginna Felts
Consultant, Business Development
Vanderbilt University Medical Center
3319 West End Avenue, Suite 920
Nashville, TN 37203

RE: Certificate of Need Application CN1406-021
Vanderbilt University Hospitals

Dear Ms. Felts:

This will acknowledge our June 12, 2014 receipt of your application for a Certificate of Need for the relocation of the obstetrical program, the newborn nursery, and the neonatal unit from VUH to MCJCHV, the addition of 23 obstetrical beds and 24 neonatal/pediatric critical care beds, the addition of 61 adult acute care beds, the renovation of 79,873 square feet and new construction of 126,686 square feet.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Thursday, June 26, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile, Item 5**

   Please clarify if Vanderbilt University Hospital in contracted with any management/operating entity. If not applicable, please note N/A.

   RESPONSE: **This question is not applicable to VUMC because there are no contracted management operating entities involved in the project. Please see revised page 2 from the application.**

2. **Section A, Applicant Profile, Item 9**

   The bed complement data chart reflects 1,159 total beds. What percentages of beds are private and semi-private?

   RESPONSE: **Of the 1,159, only 1% of the rooms will be semi-private. All other rooms at the medical center will be private. The semi-private rooms relate to circumstances where patient preference is involved (for example, members of the same family housed in the burn unit).**

   Please clarify the status of 10 unimplemented medical beds listed as unimplemented in the Bed Complement Data Chart.

   RESPONSE: **The 10 unimplemented beds refer to licensed beds that are currently not in service. These beds were originally located in semi-private rooms; however, these rooms are now private rooms, and the license will be relocated to the vertical expansion.**

3. Section A, Applicant Profile, Item 13

   The applicant has identified Value Options as a TennCare Managed Care Organization. Please clarify.

   RESPONSE: **Value Options is a Medicaid carve-out for behavioral health services for United Community Plan and Volunteer State Health Plan.**

4. **Section B, Project Description, Item 1**

   Please provide a brief description of the service area and staffing.

   RESPONSE: **The primary service area for this project includes Davidson County, the counties surrounding Davidson, and Central TN; the secondary service area includes East and West Tennessee as well as specific counties in Western Kentucky.**

   Staffing for this project will be VUMC faculty and staff.

   Please provide an overview of each phase of the VUH long-range master planning process including how this proposed project fits into that plan.

   RESPONSE: **The original plan was for a significant expansion of the MCJCHV; the Agency granted the CON for this project on January 23, 2008. As approved, the project included a new building with additional pediatric acute care beds, neonatal intensive care beds, new surgical suites and space for the relocation of obstetrical services.**

   In June 2010, MCJCHV requested and received approval to modify the approved project in a phased approach. The first phase included a 33-bed modification and acquisition of property for approximately $36.5 million. This phase was completed and opened in May 2012.

During the 2010 approval process, it was stated MCJCHV would return to the Agency with updates and requests related to additional modification phases. After occupying the first phase for more than year, a second phase has been determined. This phase will consist of a four floor vertical expansion of the existing MCJCHV, and this modification was approved on January 22, 2014.

The proposed project completes the approved three-shelled floors, as well as the original intent of consolidating neonatal and maternal services as outlined in the original plan.

Please verify the following Tables. If needed, please revise:

RESPONSE: **Please see the completed revised charts below. In addition, the "Total Beds" column was relabeled to "Total Inpatient Beds" to reflect only inpatient licensed beds and "Total Observation Beds" was added as a column in the second and third charts.**

MCJCHV Vertical Expansion (NEW CONSTRUCTION)

Floor	New Sq. ft. Construction	Requested beds	Previously approved beds	Total Inpatient Beds	Programs	What programs will backfill?
10th	1,000	2	36	38	neonatal intensive care, pediatric intensive care, and acute care patients	N/A
11th	42,000	38	0	38	neonatal intensive care, pediatric intensive care, and acute care patients	N/A
12th	42,000	38	0	38	Postpartum, newborn nursery	N/A
13th	42,000	35	0	35	Labor and Delivery, inpatient rooms (ante and postpartum)	N/A
Total	127,000	113	36	149		

VUH (RENOVATION)

Floor	Current Program	Total Sq. ft. Renovation	Requested beds	Previously approved beds	Total Inpatient Beds	Total Observation Beds	Programs	Comments
7 South	Neonatal Unit	9,245	0	0	0	17	Observation	Current NICU will relocate to renovated 4th floor of MCJCHV
4 North and 4 East	Obstetrics	49,814	0	0	61	16	Observation patients, intensive and acute care inpatient	Obstetrics will relocate at the completion of the MCJCHV 12h and 13th floor renovations
Total		59,059	0	0	61	33		

The Vanderbilt Clinic (TVC) (RENOVATION)

Floor	Total Sq. ft. Renovation	Requested beds	Previously approved beds	Total Inpatient Beds	Total Observation Beds	Programs	What programs will backfill?
1th	20,674	0	0	0	30	Observation Beds	N/A
Total	20,674	0	0	0	30		

Please clarify where oral surgery, GI/Endoscopy Services, VPEC (Per-Admission Testing) will permanently be relocated prior to renovation of The Vanderbilt Clinic.

RESPONSE:

The oral surgery physician clinic will be relocated to the Village at Vanderbilt.

At the current time, it is anticipated that VPEC (Vanderbilt Preoperative Evaluation Center) will be relocated to space allocated for additional patient amenities in the Critical Care Tower, 2nd floor.

After further review, GI/ Endoscopy space should not have been included in the narrative description of clinics to be relocated. The clinic will not be relocated.

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

How will construction be phased in at the Vanderbilt Clinic to accommodate psychiatric holding patients?

RESPONSE: **It is anticipated that the existing psychiatric holding unit will remain in place during demolition and construction of the adjacent new 6 bed psychiatric holding unit. All code required egress will be maintained throughout demolition and construction. Once the new psychiatric holding unit is completed, the old psychiatric holding unit will be demolished and the new observation unit will be completed.**

Please complete the following charts:

Current Licensed Bed Location

RESPONSE: **Please see chart below.**

Facility	Building	Floor	Before Beds	Category	Service
MCJCHV	Main	4	68	Neonatal	Neonatal
MCJCHV	Main	5	42	ICU	Pediatric ICU, Pediatric Cardiovascular ICU
MCJCHV	Main	6	43	Medicine	Medicine, Myelosuppression
MCJCHV	Main	7	43	Medicine	Medicine
MCJCHV	Main	8	43	Surgery	Surgery
VPH	Main	2	88	Psychiatry	Psychiatry
VUH	Critical Care	6	34	ICU	Neurosciences
VUH	Critical Care	7	34	Surgery	Surgery, Transplant
VUH	Critical Care	8	34	ICU	Medicine
VUH	Critical Care	9	34	ICU	Surgery
VUH	Critical Care	10	34	Medicine	Myelosuppression
VUH	Main	3	14	Medicine	Medicine
VUH	Main	4	66	Obstetrics, Neonatal	Obstetrics, Stahlman Neonatal
VUH	Main	5	49	ICU/ Surgery	Cardiovascular ICU, Cardiovascular Step-down
VUH	Main	6	50	Medicine	Cardiovascular Surgery, Neuroepilepsy
VUH	Main	7	52	Medicine, Neonatal	Cardiology, Neonatal
VUH	Main	8	56	Medicine	Medicine
VUH	Main	9	51	Surgery	General Surgery, Urology
VUH	Main	10	49	Surgery	Orthopaedics, Trauma
VUH	Main	11	52	Medicine, Surgery	Burn, Hematology Oncology, Medical Oncology
VUH	Round Wing	3	14	Surgery	Surgery
VUH	Round Wing	4	14	Surgery	Surgery
VUH	Round Wing	5	16	Medicine	Palliative Care
VUH	Round Wing	6	16	Surgery	Orthopaedics
VUH	Round Wing	7	29	Medicine	Medicine
TOTAL			1,025		

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

After Project Licensed Bed Location

RESPONSE: **Please see chart below.**

Facility	Building	Floor	After Beds	Category	Service
MCJCHV	Main	4	84	Neonatal	Neonatal
MCJCHV	Main	5	42	ICU	Pediatric ICU, Pediatric Cardiovascular ICU
MCJCHV	Main	6	43	Medicine	Myelosuppression, Medicine
MCJCHV	Main	7	43	Medicine	Medicine
MCJCHV	Main	8	43	Surgery	Surgery
MCJCHV	Main	10	38	ICU, Neonatal	Neonatal, Pediatric ICU
MCJCHV	Main	11	38	ICU, Neonatal	Neonatal, Pediatric ICU
MCJCHV	Main	12	38	Obstetric	Obstetric
MCJCHV	Main	13	35	Obstetric	Obstetric
VPH	Main	2	88	Psychiatry	Psychiatry
VUH	Critical Care	6	34	ICU	Neurosciences
VUH	Critical Care	7	34	Surgery	Transplant, Surgery
VUH	Critical Care	8	34	ICU	Medicine
VUH	Critical Care	9	34	ICU	Surgery
VUH	Critical Care	10	34	Medicine	Myelosuppression
VUH	Main	3	14	Medicine	Medicine
VUH	Main	4	61	Medicine, Surge	Medicine, Surgery
VUH	Main	5	49	ICU/ Surgery	Cardiovascular ICU, Cardiovascular Step-down
VUH	Main	6	48	Medicine	Cardiovascular Surgery, Neuroepilepsy
VUH	Main	7	36	Medicine	Cardiology
VUH	Main	8	54	Medicine	Medicine
VUH	Main	9	49	Surgery	General Surgery, Urology
VUH	Main	10	49	Surgery	Orthopaedics, Trauma
VUH	Main	11	52	Medicine	Burn, Hematology Oncology, Medical Oncology
VUH	Round Wing	3	14	Surgery	Surgery
VUH	Round Wing	4	14	Surgery	Surgery
VUH	Round Wing	5	16	Medicine	Palliative Care
VUH	Round Wing	6	16	Surgery	Orthopaedics
VUH	Round Wing	7	25	Medicine	Medicine
TOTAL			1,159		

Current Observation Bed Location

RESPONSE: **Please see chart below.**

Facility	Building	Floor	Before Obs Beds	Category	Service
MCJCHV	Main	3	12	Observation	Observation
VUH	Main	1	7	Observation	Observation
VUH	Main	5	6	Observation	Observation

After Project Observation Bed Location

RESPONSE: **Please see chart below.**

Facility	Building	Floor	After Obs Beds	Category	Service
VUH	Main	5	6	Observation	Observation
MCJCHV	Main	3	12	Observation	Observation
VUH	Main	7	17	Observation	Observation
VUH	Main	4	16	Observation	Observation
VUH	Main	1	30	Observation	Observation

5. **Section B, Project Description, Item II.A**

   There appears to be slight calculation errors in the proposed final square footage columns. If needed, please revise.

   RESPONSE: **Please see the revised square footage chart.**

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Final Location	Square Footage Renovated	Cost/ SF New	Cost/ SF Total	Cost/SF	Total
23 Adult Inpatient Beds	None	0	None	VUH 4N	14,993	0	14,993		$6,369,479
38 Adult Inpatient Beds	None	0	None	VUH 4E	11,492	0	11,492		$5,042,730
16 Adult Observation Beds	None	0	None	VUH 4E	10,131	0	10,131		$5,374,530
30 Adult Observation Beds	None	0	None	TVC 1	14,300	0	14,300		$10,337,000
17 Adult Observation Beds	None	0	None	VUH 7S	6,612	0	6,612		$2,311,250
40 NICU/Critical Care Pediatric Beds & Elevator Addition	None/ VUH 4	7,996	None	MCJCHV 11 MCJCHV 10	0	30,265	30,265		$19,113,942
59 Obstetric Beds, 14 LDRs, 3 C-Section Rooms & Normal Nursery	None/ VUH 4/ MCE 4	45,530	None	MCJCHV 12 MCJCHV 13	0	58,960	58,960		$28,577,144
B. Unit/Depart. GSF Sub-Total					57,528	89,225	146,753		Included above
C. Mechanical/ Electrical GSF					1,539	2,499	4,038		Included above
D. Circulation/ Structure GSF					20,716	34,976	55,692		Included above
E. Total GSF					**79,783**	**126,700**	**206,483**	**$373.52**	**$77,126,075**

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

6. **Section C, Need, Item 1.**

STATE HEALTH PLAN

Tennessee Code Annotated Section 68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/finance/healthplanning/). The State Health Plan guides the state in the development of health care programs and policies and in the allocation of health care resources in the state, including the Certificate of Need program. The 5 Principles for Achieving Better Health form the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Each Principle is listed below with example questions to help the applicant in its thinking.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.

   a. How will this proposal protect, promote, and improve the health of Tennesseans over time?

   RESPONSE: **The project will provide additional capacity for the many state residents who choose to access VUMC facilities. Much of the specialized care provided at the medical center is not readily available elsewhere. The presence of an academic medical center with highly specialized services will improve the health of all residents in need of those services.**

   b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?

   RESPONSE: **All outcomes are reviewed on a regular basis by numerous quality improvement teams that have been recently restructured to be more closely aligned with patient care units and services. The quality improvement committee reports directly to the Medical Center Medical Board which is responsible for the quality of medical care in all patient care areas of VUMC. Outcomes include metrics associated with adverse events, infection rates, mortality and other indicators. Specific quality improvement and patient safety interventions are implemented in response to these data.**

   c. How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?

   RESPONSE: **Feedback to physicians and unit leadership provides comparative information benchmarked internally and externally by using standards such as those in use by the Joint Commission (National Patient Safety Goals), University Healthsystem Consortium, Tennessee Center for Performance Excellence, The Leapfrog Group, and Magnet.**

2. Every citizen should have reasonable access to health care.

    a. How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.

    RESPONSE: **Additional capacity at VUMC will provide increased access for all patients regardless of geographic origin, race, gender or financial considerations. VUMC is both a Level I trauma center as well as a major safety net hospital providing a substantial amount of care each year to indigent and uninsured populations. VUMC houses many unique innovative technologies.**

    b.How will this proposal improve information provided to patients and referring physicians?

    RESPONSE: **An electronic health record is in place at VUMC that can be accessed by physicians and the MyHealthatVandy patient portal is in place for communications between patients and their physician providers and allows patients access to key portions of their own health records. Inpatient case information and discharge summaries are available to referring physicians through the Provider Communication Wizard.**

    c. How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?

    RESPONSE: **VUMC has an entire array of resources devoted to patient satisfaction, and these resources include information about disease conditions and appropriate treatment modalities for patient use. Providers are coached regarding important attributes of effective interaction with patients. In addition, an active translation service is available for those patients with difficulty with the English language.**

3. The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.

    a. How will this proposal lower the cost of health care?

    RESPONSE: **VUMC has mechanisms in place to enable the right kind of care is delivered at the right time and place. As such, system costs will be reduced if only the right intervention is implemented and inappropriate interventions are avoided.**

    b.How will this proposal encourage economic efficiencies?

    RESPONSE: **Economic efficiencies are achieved by mechanisms in place that review outcomes and appropriateness of interventions.**

c. What information will be made available to the community that will encourage a competitive market for health care services?

RESPONSE: **As the health care industry transforms, additional health care systems and associated insurance exchanges will become available to the community. These exchanges will provide transparent market data allowing for better choices by consumers.**

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

a. How will this proposal help health care providers adhere to professional standards?

RESPONSE: **All patient outcomes are reviewed on a regular basis. Feedback of comparative information to providers ensures that improvement is benchmarked both internally and externally.**

b.How will this proposal encourage continued improvement in the quality of care provided by the health care workforce?

RESPONSE: **Those trained to participate in the extensive quality control mechanisms in place at VUMC will be able to help implement similar quality improvement programs in other venues.**

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

a. How will this proposal provide employment opportunities for the health care workforce?

RESPONSE: **Additional staffing will be needed for the proposal. Even in a time of employee reductions at most hospitals, direct patient care related positions remain a priority at VUMC.**

b.How will this proposal complement the existing Service Area workforce?

RESPONSE: **VUMC participates in training programs for physicians, nurses, and allied healthcare workers with the result that many remain in the service area as trained providers.**

7. **Section C, Need, Item 1.a. (Project Specific Criteria-Construction, Renovation Expansion)**

Please address the Project Specific Criteria for Construction, Renovation, and Expansion.

Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

RESPONSE: **The beds, services, or medical equipment for each facility in the**

project will be constructed to meet all applicable standards.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

RESPONSE: **Not applicable because the project is not a relocation or replacement of an existing licensed health care institution.**

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   RESPONSE: **The proposed project is a consequence of high current inpatient and observation case volume and projections for future growth as patients continue to access the subspecialty care available at VUMC. Patients from an extended service area, including patients from out of state, utilize the facility. As a consequence and as indicated in the graphs provided, occupancy remains high.**

   In order to meet these occupancy pressures, additional capacity is necessary. Observation cases are an increasing concern in that, even as short term patients, they utilize a bed that would otherwise house an inpatient.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

   RESPONSE: **The completion of shelled floors at the MCJCHV will provide consolidation of maternal and neonatal services while at the same time freeing up space that can be cost effectively renovated for additional inpatient and observations beds to accommodate the increasing occupancy pressures at VUH.**

8. **Section C, Need, Item 1.a. (Project Specific Criteria-Acute Care Bed Need Services), Question 2.a. and 2.b.**

The chart of licensed bed occupancy levels of all facilities in the applicant's service area is noted. Please provide the percentage of hospitals in the applicant's service area that have an occupancy level greater than or equal to 80%. In addition, please add a row to the chart that totals and/or averages each column.

RESPONSE: **According to the 2012 Joint Annual Report of Hospitals, only 2% of the hospitals have occupancy of greater than 80%. Please see the revised chart below with the average for each column.**

Facility	County	Licensed Beds	Staffed Beds	Admissions	Days	Occupancy of Licensed Beds
Methodist Medical Center of Oak Ridge	Anderson	301	255	11,575	49,355	45%
Heritage Medical Center	Bedford	60	60	2,271	7,326	33%
Camden General Hospital	Benton	25	12	360	1,971	22%
Erlanger-Bledsoe	Bledsoe	25	25	214	2,751	30%
Blount Memorial Hospital	Blount	304	238	12,385	53,384	48%
Skyridge Medical Center	Bradley	251	177	9,499	36,171	39%
Skyridge Medical Center Westside	Bradley	100	30	968	4,594	13%
Jellico Community Hospital, Inc.	Campbell	54	31	1,688	5,033	26%
Tennova Healthcare Lafollette Medical Center	Campbell	66	66	2,265	11,295	47%
Stones River Hospital	Cannon	60	50	821	6,667	30%
Baptist Memorial Hospital-Huntingdon	Carroll	70	33	657	2,946	12%
McKenzie Regional Hospital	Carroll	45	35	1,763	4,392	27%
Sycamore Shoals Hospital	Carter	121	79	4,108	16,105	36%
Centennial Medical Center at Ashland City	Cheatham	12	12	194	1,551	35%
Claiborne County Hospital	Claiborne	85	39	1,590	7,523	24%
Cumberland River Hospital	Clay	36	34	789	4,939	38%
Tennova Healthcare – Newport Medical Center	Cocke	74	36	2,628	7,602	28%
Harton Regional Medical Center	Coffee	135	107	5,543	22,186	45%
Medical Center of Manchester	Coffee	25	16	1,706	5,814	64%
United Regional Medical Center	Coffee	54	36	1,011	3,551	18%
Cumberland Medical Center	Cumberland	189	123	6,114	23,205	34%
Baptist Hospital	Davidson	683	453	29,792	125,686	50%
Centennial Medical Center	Davidson	657	630	25,830	147,903	62%
Metro Nashville General Hospital	Davidson	150	116	4,675	18,919	35%
Saint Thomas Hospital	Davidson	541	404	22,621	100,202	51%
Skyline Medical Center	Davidson	213	209	9,773	52,021	67%
Skyline Medical Center Campus	Davidson	182	110	3,646	26,727	40%
Southern Hills Medical Center	Davidson	132	81	4,077	17,845	37%
Summit Medical Center	Davidson	188	137	10,779	42,722	62%
The Center for Spinal Surgery	Davidson	23	23	1,144	1,519	18%
Vanderbilt University Hospitals	Davidson	985	966	53,818	283,062	79%
Decatur County General Hospital	Decatur	40	27	843	3,410	23%
DeKalb Community Hospital	DeKalb	71	56	1,136	4,107	16%

Horizon Medical Center	Dickson	157	120	4,391	18,099	32%
Dyersburg Regional Medical Center	Dyer	225	120	4,925	13,367	16%
Methodist Healthcare - Fayette	Fayette	46	10	214	704	4%
Jamestown Regional Medical Center	Fentress	85	54	1,987	6,186	20%
Emerald - Hodgson Hospital	Franklin	21	21	519	1,898	25%
Southern Tennessee Medical Center	Franklin	131	89	4,435	21,031	44%
Gibson General Hospital	Gibson	77	32	336	1,224	4%
Humboldt General Hospital	Gibson	62	30	492	2,058	9%
Milan General Hospital	Gibson	70	28	319	1,766	7%
Hillside Hospital	Giles	95	81	1,734	7,680	22%
Laughlin Memorial Hospital	Greene	140	140	4,105	16,643	33%
Takoma Regional Hospital	Greene	100	30	2,657	11,424	31%
Lakeway Regional Hospital	Hamblen	135	65	3,506	14,689	30%
Morristown - Hamblen Healthcare System	Hamblen	167	147	7,428	26,972	44%
Erlanger East	Hamilton	41	37	4,909	10,382	69%
Erlanger Medical Center	Hamilton	690	491	27,238	133,260	53%
Erlanger North	Hamilton	12	12	268	3,746	86%
Memorial Healthcare System, Inc.	Hamilton	336	336	21,395	99,485	81%
Memorial North Park	Hamilton	69	69	4,194	16,982	67%
Parkridge East Hospital	Hamilton	128	113	5,393	19,103	41%
Parkridge Medical Center, Inc.	Hamilton	275	177	8,270	40,134	40%
Parkridge Valley Hospital	Hamilton	140	140	3,073	39,153	77%
Wellmont Hancock County Hospital	Hancock	10	10	261	1,199	33%
Bolivar General Hospital	Hardeman	51	23	309	821	4%
Hardin Medical Center	Hardin	58	49	1,645	5,679	27%
Wellmont Hawkins County Memorial Hospital	Hawkins	50	46	1,291	3,530	19%
Haywood Park Community Hospital	Haywood	62	36	593	1,592	7%
Henderson County Community Hospital	Henderson	45	45	818	2,449	15%
Henry County Medical Center	Henry	142	101	4,063	17,227	33%
Hickman Community Hospital	Hickman	15	15	-	-	0%
Patients' Choice Medical Center of Erin	Houston	25	25	643	2,872	31%
Three Rivers Hospital	Humphreys	25	25	487	1,699	19%
Tennova Healthcare - Jefferson Memorial Hospital	Jefferson	58	58	2,300	9,456	45%
Johnson County Community Hospital	Johnson	2	2	26	53	7%
East Tennessee Children's Hospital	Knox	152	152	5,901	40,530	73%
Fort Sanders Regional Medical Center	Knox	517	378	18,368	90,737	48%
Mercy Medical Center West	Knox	101	101	4,808	17,612	48%
North Knoxville Medical Center	Knox	108	72	3,281	14,922	38%
Parkwest Medical Center	Knox	307	297	17,690	77,911	70%
Tennova Healthcare	Knox	111	243	15,563	74,903	185%
University of Tennessee Memorial Hospital	Knox	581	534	26,236	140,304	66%

Lauderdale Community Hospital	Lauderdale	25	25	535	3,050	33%
Crockett Hospital	Lawrence	99	80	2,587	9,211	25%
Lincoln Medical Center	Lincoln	59	59	1,995	7,803	36%
Fort Loudoun Medical Center	Loudon	50	30	1,724	6,195	34%
Macon County General Hospital	Macon	25	25	946	3,775	41%
Jackson - Madison County General Hospital	Madison	635	601	30,392	156,148	67%
Regional Hospital of Jackson	Madison	152	128	7,565	28,378	51%
Grandview Medical Center	Marion	70	63	1,900	10,802	42%
Marshall Medical Center	Marshall	25	12	207	675	7%
Maury Regional Hospital	Maury	255	215	13,641	45,838	49%
Athens Regional Medical Center	McMinn	118	63	2,747	9,407	22%
McNairy Regional Hospital	McNairy	45	45	1,646	5,165	31%
Sweetwater Hospital Association	Monroe	59	59	2,459	10,587	49%
Gateway Medical Center	Montgomery	270	220	13,234	45,331	46%
Baptist Memorial Hospital - Union City	Obion	173	85	3,039	10,551	17%
Livingston Regional Hospital	Overton	114	82	3,385	16,524	40%
Perry Community Hospital	Perry	53	25	904	6,000	31%
Copper Basin Medical Center	Polk	25	25	902	4,308	47%
Cookeville Regional Medical Center	Putnam	247	243	14,346	64,089	71%
Rhea Medical Center	Rhea	25	25	1,014	3,535	39%
Roane Medical Center	Roane	105	36	1,694	6,620	17%
NorthCrest Medical Center	Robertson	109	66	4,513	17,053	43%
Middle Tennessee Medical Center	Rutherford	286	268	18,607	70,595	68%
StoneCrest Medical Center	Rutherford	101	101	4,934	15,472	42%
LeConte Medical Center	Sevier	79	69	4,924	14,324	50%
Baptist Memorial Hospital	Shelby	706	573	25,440	170,707	66%
Baptist Memorial Hospital - Collierville	Shelby	81	81	2,451	9,655	33%
Baptist Memorial Hospital for Women	Shelby	140	140	11,572	37,666	74%
Delta Medical Center	Shelby	243	177	3,965	33,171	37%
Lebonheur Children's Medical Center	Shelby	255	228	9,488	57,743	62%
Methodist Healthcare - Memphis Hospitals	Shelby	617	416	18,230	120,042	53%
Methodist Hospital - Germantown	Shelby	309	309	19,678	81,132	72%
Methodist Hospital - North	Shelby	246	207	10,971	62,286	69%
Methodist Hospital - South	Shelby	156	144	7,676	31,682	56%
Saint Francis Hospital	Shelby	519	326	15,830	90,401	48%
Saint Francis Hospital - Bartlett	Shelby	196	156	7,139	35,317	49%
Saint Jude Children's Research Hospital	Shelby	78	64	2,988	15,667	55%
The Regional Medical Center at Memphis	Shelby	631	294	15,779	96,178	42%
Riverview Regional Medical Center North	Smith	63	50	805	3,652	16%
Riverview Regional Medical Center South	Smith	35	35	1,470	7,129	56%
Indian Path Medical Center	Sullivan	239	169	7,030	26,312	30%
Wellmont - Holston Valley Medical Center,	Sullivan	505	339	19,232	88,387	48%

Inc.						
Wellmont Bristol Regional Medical Center	Sullivan	312	261	15,304	65,052	57%
Hendersonville Medical Center	Sumner	110	96	5,551	20,434	51%
Portland Medical Center	Sumner	38	-	-	-	0%
Sumner Regional Medical Center	Sumner	155	117	7,422	29,432	52%
Baptist Memorial Hospital - Tipton	Tipton	100	44	1,881	5,012	14%
Trousdale Medical Center	Trousdale	25	21	390	1,680	18%
Unicoi County Memorial Hospital, Inc.	Unicoi	48	7	1,083	4,284	24%
River Park Hospital	Warren	125	48	3,263	11,625	25%
Franklin Woods Community Hospital	Washington	80	80	4,596	16,125	55%
Johnson City Medical Center	Washington	501	501	27,008	134,793	74%
Wayne Medical Center	Wayne	80	32	591	1,991	7%
Volunteer Community Hospital	Weakley	100	65	2,276	6,912	19%
White County Community Hospital	White	60	44	1,438	7,189	33%
Williamson Medical Center	Williamson	185	185	9,618	35,700	53%
University Medical Center	Wilson	170	170	6,156	25,474	41%
Average		167	132	6,554	30,658	50%

Please provide a brief description of the following referenced outstanding service area projects listed in the application: Monroe Carell Jr. Children's Hospital at Vanderbilt, CN0710-075; Vanderbilt University Hospital, CN0606-037; and Summit Medical Center CN1402-004.

RESPONSE: **Please find the description provided on the Health Services Development Agency's Certificate of Need Projects 2000-Present document.**

Monroe Carell Jr. Children's Hospital at Vanderbilt CN0710-075
Expansion of the existing Monroe Carell Jr. Child. Hsp as an adjacent building to provide 90 additional pediatric acute critical care beds, 36 NICU (16 rltd),expanded OB service with 36 relocated postpartum beds, 12 new antepartum,16 LD (12 rltd), 2 Ors

Vanderbilt University Hospital CN0606-037
Continuance of facility's master plan: addition of 3rd bed tower with redistribution of 141 SNF beds to acute care beds; renovation and expansion of cardiac cath labs and hybrid ORs; addition of 14 newly constructed OR suites; and decommissioning 2 ORs.

Summit Medical Center CN1402-004
Conversion of existing space to add 8 inpatient medical/surgical beds on the 7th floor of its facility increasing the hospital bed complement from 188 to 196 hospital beds.

The "VUH Daily occupancy percent based on licensed beds + observation" chart on page 12 is noted. The applicant states VUH's daily occupancy consistently operates above 90% over the last several years. However, please clarify the average percentage of occupancy consisting of inpatient, observation, and ED holds for the time period 4/1/11 through 3/31/14 that this chart represents.

The "MCJCHV Daily occupancy percent based on licensed beds + observation" chart on page 14 is noted. The applicant states MCJCHV's daily occupancy consistently operates above 80% over the last several years. However, please clarify the average percentage of occupancy consisting of inpatient, observation, and ED holds for the time period 4/1/11 through 3/31/14 that this chart represents.

RESPONSE: **Please find attached the detailed percentages for inpatient, observation and ED holds for the time period represented in the chart for VUH and MCJCHV. VUMC's financial system does not specify the percentage of inpatients, observation, and ED holds on a daily basis for historic time periods.**

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

Section C, Need, Item 5

Please provide the following utilization by services as indicated in the following table:

RESPONSE: **Please see the utilization by services provided below.**

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

	2011	2012	2013	FY20 (Y1)	FY21 (Y2)
MCJCHV					
Medical/Surgical					
Beds	124	129	129	-	-
Admissions	7,415	7,383	8,324	-	-
Days	37,067	35,513	39,498	-	-
ADC	101.6	97.3	108.2	-	-
ALOS	5.0	4.8	4.7	-	-
% Occupancy	81.9%	75.4%	83.9%	-	-
Neonatal Critical Care					
Beds	83	100	100	24	24
Admissions	1,179	1,135	1,154	264	264
Days	25,666	26,578	30,669	7,008	7,008
ADC	70.3	72.8	84.0	19.2	19.2
ALOS	21.8	23.4	26.6	26.5	26.5
% Occupancy	84.7%	72.8%	84.0%	80.0%	80.0%
Pediatric Intensive Care					
Beds	36	42	42	-	-
Admissions	1,352	1,471	1,467	-	-
Days	11,279	10,075	11,708	-	-
ADC	30.9	27.6	32.1	-	-
ALOS	8.3	6.9	8.0	-	-
% Occupancy	86%	66%	76%	-	-
Neonatal Unit					
Beds					
Admissions					
Days					
ADC					
ALOS					
% Occupancy					
Observation Unit					
Beds	12	12	12	-	-
Admissions				-	-
Days*	551	571	437	-	-
ADC	1.5	1.6	1.2	-	-
ALOS				-	-
% Occupancy	12.6%	13.0%	10.0%	-	-
VUH					
Medical/Surgical					
Beds	590	626	660	84	84
Admissions	35,813	36,748	39,465	6,244	7,693
Days	174,304	176,825	189,311	31,111	37,434
ADC	477.5	484.5	518.7	85.2	102.6
ALOS	4.9	4.8	4.8	5.0	4.9
Total VUH Occupancy (Inpatient Only with Incremental)	80.9%	77.4%	78.6%	81.2%	83.5%
Observation Unit					
Beds	13	13	13	56	56
Admissions				-	-
Days**	2,514	2,773	2,470	16,352	16,352
ADC	6.9	7.6	6.8	44.8	44.8
ALOS				-	-
% Occupancy	53.0%	58.4%	52.1%	80.0%	80.0%

*The MCJCHV Observation Unit functions as an overflow unit since every effort is made to place pediatric patients in an inpatient unit. Placement of observation patients can occur in any available inpatient unit.

Total observation patients excluding those in above Observation Unit	7,927	8,890	7,292	-	-

**The VUMC Observation Unit totals only represent a portion of the total observation patients. The remaining is spread across various locations including the ED, Surgical Recovery, and other outpatient locations. Occupancy for the 56 incremental beds represents patients relocated from various inpatient and outpatient units that historically serviced that population.

Total observation patients excluding those in above Observation Unit	15,079	21,812	21,489	10,525	10,632

9. **Section C, Need, Item 6**

The utilization and occupancy tables are noted. However, please clarify how the average daily census in the VUH chart in FY20 and FY21 of 80 and 96 can be higher than the licensed beds of 61 for both years.

RESPONSE: **The average daily census provided in the chart is a result of relocating observation patients out of inpatient beds and into the new proposed dedicated observation units. In other words, the numerator represents volume in new beds and existing beds, while the denominator represents just the new beds based on the categories in the requested chart.**

10. **Section C. Economic Feasibility Item 1 (Project Cost Chart)**

The documentation from a licensed architect or construction professional is noted. However, please provide the following and resubmit:

1) a general description of the project,
2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and
3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

RESPONSE: **Please see attached letter.**

Please list the cost of each moveable equipment in A.8 in the Project Costs Chart that cost over $50,000.

RESPONSE: **Please see the chart below.**

Allowance Monitoring Clinical Config and Installation	$110,000
Anesthesia Machine	$95,000
Blood Gas Analyzer	$50,000
Central station monitor	$55,000
Central station monitor	$55,000
Central station monitor	$55,000
GE Central Station Monitor	$60,000
GE Ultrasound	$180,000
Medication dispenser	$59,425
Medication dispenser	$59,425
Medication dispenser	$59,425
Phillips Central Station and Controller	$55,000
Phillips Central Station Monitor	$68,113
Phillips X-ray	$197,000

11. Section C, Economic Feasibility, Item 2

Please clarify the percentage of cash and public issued securities that will be used to finance the proposed project.

RESPONSE: **Currently unknown and dependent on prevailing market conditions at project initiation. However, current strategic plans include $70.8 million for debt financing or 60% of the project costs.**

Please describe the public issued securities Vanderbilt will use to finance this project. In your response please include the interest rate, anticipated bond maturity, and any call and inflation risks.

RESPONSE: **Vanderbilt's current outstanding debt portfolio includes commercial paper, long term debt with repurchase requirements, and long term fixed rate debt with various rates and maturities. The structure of future issuances will likely emulate the current portfolio with the terms currently unknown and dependent on prevailing market conditions at the time of issuance. However, for planning purposes, VUMC is assuming a fixed-rate issuance, for 15 years, at a 7.25% interest rate, non-callable debt.**

Please provide documentation that VUH will be capable of obtaining publicly issued securities in the amount needed to finance the proposed project.

RESPONSE: **Vanderbilt currently has strong credit ratings of Aa2/AA+/AA by Moody's/Fitch/S&P. Previous lending experience suggests that publicly issued debt is readily available to organizations maintaining these rating levels**

With $3 billion in cash and unrestricted investments, please explain the rationale of seeking tax-exempt debt.

RESPONSE: **Vanderbilt continually manages its mix of cash and debt to maintain both short and long term liquidity and support financial stability.**

13. **Section C, Economic Feasibility, Item 3**

The HSDA Hospital Construction Cost per Square Foot chart is noted. However, please list the proposed project's renovation and construction cost and compare the costs to approved Project construction costs between 2010-2012.

RESPONSE: **The proposed project's cost per square foot is $373.55. Compared to other approved CON projects, this cost is more expensive than the 3rd quartile included in the chart below.**

Hospital Construction Cost per Square Foot
Approved Projects, 2010-2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

14. **Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)**

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Projected Data Chart provided at the end of this request for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

RESPONSE: **Please see the revised Historical and Projected Data Charts.**

Please respond to the following questions regarding the Historical Data Chart:

- Please explain the onetime reduction in net revenue of $126,000,000 attributable to a change in the estimated net realizable value of patient accounts receivable.

RESPONSE: **During fiscal 2013, due to a noted trend of an increasing balance of aggregate patient care net receivables, along with corresponding cash collections not being realized, Vanderbilt initiated an extensive analysis of its patient care net revenue accounting and estimation processes and systems, including in-depth hindsight liquidation analysis. This analysis resulted in VUMC recording an unfavorable $126 million change in estimate of the net realizable value of patient receivables during fiscal 2013.**

- Please clarify the reason Charity Care increased from $312,846,669 in 2012 to $374,555,880 in 2013.

RESPONSE: **Vanderbilt maintains a policy which sets forth the criteria pursuant to those healthcare services that are provided without expectation of payment or a reduced rate to patients who have minimal financial resources to pay for their medical care. VUMC experienced an increase in the provision for charity care in FY13 as a result of patients' eligibility pursuant to this policy.**

- Why did salaries and wages and Physician's salaries and wages increase from 2012 to 2013 while utilization remained from 81% to 82.3% from 2011 to 2013?

RESPONSE: **The Utilization Data (A) in the Historical Data Chart represents inpatients only. However, the revenue and expenses represent the entire medical center, including the hospitals and clinics (on campus and outreach community clinics). Tremendous growth has occurred in the ambulatory arena resulting in increases in provider expense.**

- Why did supplies increase from $362,423,688 in 2012 to $410,504,178 in 2013?

RESPONSE: **Similar to the question above, the supply increases in cost are associated with ambulatory patient growth and substantial increase in pharmaceutical costs.**

Since the applicant experienced an income loss of $23,201,131 in 2013, please provide a Projected Data Chart for VUH for Year 2020 and 2021.

RESPONSE: **The projected data chart was completed for the proposed project as instructed in the application. A one-time adjustment to revenue, which resulted in an operating loss inclusive of capital expenditures in FY13 only, is not relevant information for future projections.**

Please provide a VUH Projected Data Chart for the current year that reflects financial performance.

RESPONSE: **VUMC operates on a July 1 to June 30 fiscal year, and the audited financials are not published until the following November. As a result, the most recent data are provided in the CON application, FY13.**

Please clarify the reason there are no gross revenue from Outpatient Services in the Projected Data Chart?

RESPONSE: **The project does not include an outpatient component; and therefore, projections were not included.**

Please clarify the reason there are no expense allocated in the Projected Data Chart for the following: Physician's Salaries and Wages, Taxes, Depreciation, Rent, and other expenses.

RESPONSE: **The Historic Data Chart includes the entire medical center where certain taxes, depreciation and rent categories are relevant.**

Project specific physician salaries and wage structures are propriety to the Vanderbilt School of Medicine.

Depreciation was included in the Projected Data Chart Other Expenses category and has now been identified separately in the updated chart.

Rent is not applicable to this project.

Taxes are not provided for this component of the medical center activity.

If this project will be financed with public securities, why is there no amounts assigned to the retirement of principal and interest in the Projected Data Chart?

RESPONSE: **The terms of future debt are currently unknown and dependent on prevailing market conditions at the time of issuance. However, current plans estimate debt amounts of up to $70.8 million for the project. VUMC has added related amounts of principle and interest to the revised project data chart.**

15. **Section C, Economic Feasibility, Item 8**

Please discuss Vanderbilt's Evolve to Excel (E2E) initiative and how it will address any possible payment reductions from Medicare and Medicaid.

RESPONSE: **In response to ongoing financial pressures from declining reimbursements for the treatment of Medicare and Medicaid patients along with reductions to federal research**

funding due to the nation's ballooning deficit, VUMC implemented a comprehensive program designed to sharpen operational practices throughout the institution to better meet the economic realities facing the future of healthcare delivery and research. The program provides a focused effort to increase the efficiency and effectiveness VUMC's administration and operational support services.

After careful analysis of financial models associated with federal revenue streams, it was determined that more than $50 million in savings during FY14 will be needed.

Evolve to Excel (E2E) has been designed to achieve this operational goal. E2E is intended to be a comprehensive effort to help bring successful transformation throughout the medical center in response to the rapidly changing landscape for healthcare delivery and academic research.

Goals for E2E include: to ensure functions operate with total system effectiveness; streamline decision making while simplifying governance; develop processes designed around customer service and removing barriers to processes and efficiencies.

As medical centers across the county are facing lower clinical and research revenue streams, VUMC intends to lead the nation in how it manages its' administrative and management support activities. E2E embodies this commitment to leadership in clinical care, research, and education.

Possible payment reductions from Medicare and Medicaid were factors in VUMC's decision to undertake its' E2E initiatives.

What has been the financial impact of the reductions to federal research funding and the federal sequester on the financial viability of Vanderbilt Medical Center?

RESPONSE: **The certificate of need process is specific to clinical initiatives. Research funding is reported outside of the hospitals and clinics. Both the federal sequester and potential reductions in Medicare and Medicaid payments were considered in VUMC's efforts to develop an appropriate cost structure.**

16. **Section C, Economic Feasibility, Item 10**

The current assets and current liabilities could not be located in the provided Financial Documents. Please include balance sheets that includes current assets and current liabilities since a portion of the proposed project will be financed with cash reserves.

RESPONSE: **Please see the attached chart extracted from page 5 of the 2013 Financial Report for Vanderbilt University. A more detailed balance sheet extracted from page 15 of the Report is also attached. Vanderbilt University, which includes the medical center, operates under one federal tax identification number.**

17. **Section C, Contribution to the Orderly Development of Health Care, Item 3**

Please describe the care partner clinical position.

RESPONSE: **Care partners assist with the implementation of patient care under the supervision of a registered nurse and are currently used throughout the medical center. A care partner might also be referred to as patient care technicians or patient care assistants at other medical centers.**

What type of clinical work force reductions are scheduled for 2014 and 2015?

RESPONSE: **No system wide reductions are planned for the clinical enterprise in 2014 and 2015.**

18. **Section C, Contribution to the Orderly Development of Health Care, Item 5**

Please verify that VUH has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff.

RESPONSE: **Yes, VUMC has reviewed and understands all licensing and certification requirements as required by the State of Tennessee for medical/ clinical staff.**

19. **Section C, Contribution to the Orderly Development of Health Care, Item 8 and 9**

The two questions apply to the applicant. Please respond in a manner other than "Not applicable".

Item 8:
Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE: **No such final orders or judgments exist.**

Item 9:
Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

RESPONSE: **No such final civil or criminal judgments for fraud or theft exist.**

20. **Project Completion Forecast Chart**

The applicant is projecting completion of the project in 2019. Please clarify if the applicant will request an extension of the CON from the normal three year period.

RESPONSE: **Yes, VUMC will request a three year extension beyond the normal**

three year period for the proposed CON.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is August 18, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enclosure

Financial Overview

Vanderbilt manages its operations with a focus on achieving long-term financial equilibrium. In an unpredictable external environment with such challenges as uncertain research funding levels, concerns about rising health care costs, and the impact of market changes, Vanderbilt remains steadfast in setting priorities in an effort to excel at research, discovery, service, and education for generations to come. Fiscal 2013 was a challenging year that produced sound financial results.

The university's total net assets grew $320 million in fiscal 2013, compared to a decrease of $71 million in fiscal 2012, as positive investment returns were experienced and LIBOR rates improved, positively impacting the value of interest rate exchange agreements. The university's change in unrestricted net assets from operating activities in fiscal 2013 was negative $44 million, a decrease from $158 million in fiscal 2012. This decrease primarily was related to a change in the balance sheet estimate of the net realizable value of patient receivables.

The demand for a Vanderbilt education remains strong. The number of applications received for both undergraduate and professional schools achieved new records. Undergraduate applications for the fall of 2012 grew 14.1% to a total of 28,348 with a selectivity rate of 14.2%, compared to 16.4% for the fall of 2011—and the fall of 2013 selectivity rate was at a record 12.7% level.

Vanderbilt remains committed to ensuring that young people of every background can attend the university, creating a dynamic learning community that benefits every student. Vanderbilt's decision to replace need-based loans with scholarship support through Opportunity Vanderbilt (OV) gives talented undergraduates opportunities to consider career choices and educational dreams without the prospect of significant debt.

Vanderbilt continues to lead in research. Faculty recruiting and retention remain vibrant, enhancing the overall educational experience for all Vanderbilt students. Fundraising continues to grow and expand in support of Vanderbilt's long-term priorities.

Despite current environmental challenges, Vanderbilt is positioned to remain a distinguished research institution with world-class faculty and staff, topnotch students, and outstanding health care services. While the university is well-positioned to sustain excellence and take advantage of future opportunities, it is important to remain keenly aware of the challenges ahead.

Financial Position

As of June 30, 2013, Vanderbilt's financial position consisted of assets totaling $7,606 million and liabilities totaling $2,267 million, resulting in net assets of $5,339 million.

Summary of Financial Position
as of June 30, in millions

	2013	2012
ASSETS		
Working capital cash and investments	$ 1,120	$ 1,210
Endowment and other cash and investments	4,054	3,776
Accounts and contributions receivable	565	675
Property, plant, and equipment, net	1,781	1,728
Prepaid expenses and other assets	86	82
Total assets	**$ 7,606**	**$ 7,471**
LIABILITIES		
Payables and accrued liabilities	$ 626	$ 636
Deferred revenue	93	119
Interest rate exchange agreements	207	316
Taxable debt for liquidity	250	250
Project and equipment-related debt	1,091	1,131
Total liabilities	**2,267**	**2,452**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt University	2,785	2,560
Unrestricted net assets related to non-controlling interests	187	201
Temporarily restricted net assets	1,235	1,191
Permanently restricted net assets	1,132	1,067
Total net assets	**5,339**	**5,019**
Total liabilities and net assets	**$ 7,606**	**$ 7,471**

Total net assets include Vanderbilt's endowment valued at $3,635 million as of June 30, 2013. Net assets associated with capital infrastructure totaled $690 million, which represents the university's property, plant, and equipment, net of accumulated depreciation and capital-related debt. Other net assets, which totaled $1,014 million as of June 30, 2013, include current assets and current liabilities, net of mark-to-market adjustments on interest rate exchange agreements, and net assets related to noncontrolling interests.

Vanderbilt's assets, totaling $7,606 million as of June 30, 2013, reflect a 1.8% increase from the prior year. This increase primarily is attributable to increases in the endowment.

Total liabilities decreased by $185 million to $2,267 million as of June 30, 2013. This decrease is attributable largely to a decrease in the mark-to-market liability associated with the university's interest rate exchange agreements.

The summary of financial position shown on this page summarizes several asset and liability lines from the consolidated statements of financial position. The summary on this page also segregates the university's cash and investments into: (a) working capital, which consists of operating accounts and proceeds from taxable liquidity borrowings, and (b) endowment and other cash and investments. The summary segregates debt between taxable debt designated for liquidity enhancement and capital-related debt.

Vanderbilt University
Consolidated Statements of Financial Position

As of June 30, 2013 and 2012 (in thousands)

	2013	2012
ASSETS		
Cash and cash equivalents	$ 845,472	$ 912,419
Accounts receivable, net	413,172	518,566
Prepaid expenses and other assets	85,675	82,167
Contributions receivable, net	70,302	72,334
Student loans and other notes receivable, net	43,582	45,409
Investments	4,141,408	3,872,014
Investments allocable to noncontrolling interests	186,901	201,386
Property, plant, and equipment, net	1,781,293	1,727,611
Interests in trusts held by others	38,091	39,257
Total assets	**$ 7,605,896**	**$ 7,471,163**
LIABILITIES		
Accounts payable and accrued liabilities	$ 226,643	$ 228,422
Accrued compensation and withholdings	235,169	245,859
Deferred revenue	93,029	118,826
Actuarial liability for self-insurance	107,514	105,543
Actuarial liability for split-interest agreements	33,968	34,171
Government advances for student loans	22,052	22,113
Commercial paper	214,011	264,075
Long-term debt and capital leases	1,127,458	1,117,029
Fair value of interest rate exchange agreements, net	206,733	315,577
Total liabilities	**2,266,577**	**2,451,615**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt	2,784,933	2,559,802
Unrestricted net assets related to noncontrolling interests	186,901	201,386
Total unrestricted net assets	2,971,834	2,761,188
Temporarily restricted net assets	1,235,066	1,191,216
Permanently restricted net assets	1,132,419	1,067,144
Total net assets	**5,339,319**	**5,019,548**
Total liabilities and net assets	**$ 7,605,896**	**$ 7,471,163**

The accompanying notes are an integral part of the consolidated financial statements.

SUPPLEMENTAL #1
June 25, 2014
3:44 pm

BLAIR + MUI DOWD ARCHITECTS, PC
DONALD BLAIR ARCHITECTS
100 LAFAYETTE ST STE. 604
NEW YORK, NY 10013
TEL 212.941.8825
WWW.BMDARCH.NET

June 23, 2014

To Whom It May Concern:

Subject: Vanderbilt University Medical Center CON Application
Licensed Architect Verification

The proposed project will expand and renovate the existing Vanderbilt University Medical Center facilities to increase the institutional capacity by 108 beds. Approximately 79,783 gsf will be renovated, and 126,686 gsf of new space will be constructed. The major components of this project include the build out of three shelled bed floors recently approved in the MCJCHV expansion (CN0710-075). Two floors will include the obstetrical program relocated from VUH as well as an additional 23 obstetrical beds (+21 antepartum/ postpartum and +2 labor and delivery rooms (LDRs)). In addition, two C-section rooms will be relocated and one C-section room will be added. The normal newborn nursery will also be relocated from VUH. One floor will include the addition of 22 neonatal/ pediatric critical care beds and the relocation of the Stahlman 16-bed neonatal unit from the 4th floor of VUH. The remaining 2 neonatal/ pediatric critical care beds requested will be added to the 36 beds (CN0710-075) on the first floor of the MCJCHV vertical expansion. Renovation of the vacated (obstetrical) space in VUH will be backfilled with 61 adult acute care inpatient beds. Addition of three observation units, with a total of 63 observation beds, will involve renovating existing space in TVC 1, VUH 7S, and VUH 4E.

Our estimate of the cost to construct all components of this project, based on a current dollars-per-square-foot is $77,126,075. The design documents will be developed to the best of our ability, to provide a physical environment in compliance with all applicable federal, state and local construction codes, standards, specifications, and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Sincerely,

Donald Blair

Donald Blair, AIA, ACHA
Tennessee License #016783

COPY
SUPPLEMENTAL-2

Vanderbilt University Hospital
CN1406-021

VANDERBILT UNIVERSITY MEDICAL CENTER

Business Development

SUPPLEMENTAL

June 27, 2014

Dear Mr. Earhart:

Enclosed are an original and two copies of responses to the second request for supplemental information for Certificate of Need application number CN1406-021 for Vanderbilt University Hospitals. Thank you for your help in reaching a determination of completeness for this application.

Respectfully,

Ginna Felts

Ginna Felts
Business Development

1. Section C, Economic Feasibility, Item 2

It is noted the applicant will seek 70.8 million dollars in publicly traded issued securities to finance the proposed project. A letter dated June 12, 2014 from VUH's Associate Vice Chancellor for Finance indicated the project will be provided through tax exempt debt and cash reserves. As indicated in the application please provide a copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance. Please revise and resubmit page 29 of the application to indicate the proposed project will be financed through a combination of cash reserves and tax-exempt debt.

RESPONSE: Section C, Item 2, requests a copy of a preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance. We have had various affirmative conversations to date with our underwriters/banks around our ability to issue debt at these levels and higher. However, due to the long time frame for the project planning phase, we have not entered into any formal agreements with a banker nor will we contact the issuing authority at this time. We will request a formal non-binding letter from a major commercial bank documenting their assessment that we have the financial strength to issue debt at these levels. However, it's not possible to obtain a letter by today because of the unavailability of the appropriate individuals, but we are confident that a letter can be obtained in the next few days to confirm the favorable view of the bank and will submit as soon as received.

3319 West End Avenue
Suite 920 Crystal Terrace
Nashville, TN 37203

www.mc.vanderbilt.edu

SUPPLEMENTAL

JUN 27 PM 2:52

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Vanderbilt University Hospitals

I, Ginna Felts, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Ginna Felts

CONSULTANT, BUSINESS DEVELOPMENT

Sworn to and subscribed before me, a Notary Public, this the 27th day of June, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

Jennifer Hygrell

NOTARY PUBLIC

My commission expires May 5, 2015.

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

HF-0043

Revised 7/02

2. Section C, Economic Feasibility, Item 3

The HSDA Hospital Construction Cost per Square Foot chart is noted. The applicant combined the renovation and construction cost for a combined cost per square foot of $373.55. Please complete the following table and compare the costs to hospital construction projects approved between 2010-2012.

RESPONSE: Please see the completed requested table below. Compared to the approved projects between 2010 and 2012, this project remains higher than the 3rd quartile for both renovation and new construction projects.

	Square Feet	Cost PSF
Renovated	79,783	$368.94
New Construction	126,700	$376.41
Total	206,483	$373.52

Hospital Construction Cost per Square Foot
Approved Projects, 2010-2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

3. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

As requested, please complete the attached revised Projected Data Chart located at the end of this document. Please include a total for the Total Capital Expenditures line.

The clarification that physician wages and wage structures are proprietary to the Vanderbilt School of medicine is noted. The applicant is being requested to provide an explanation of why there are no expenses allocated in the Projected Data Chart for physician's salaries and wages. However, it is noted aggregate data of physician salaries and wages are listed in the Historical Data Chart for the Years 2011-2013. The information requested by HSDA is aggregate physician salary data only. Please provide and revise the projected data chart for physician's salaries and wages assigned to the proposed hospital proejct. If this information cannot be provided, please clarify why this expense is not assigned to this proposed project.

RESPONSE: Please see the revised Projected Data Chart below with the total for the Capital Expenditures line.

SUPPLEMENTAL

Physician's salaries and wages reported in the Historical Data Chart for the years 2011-2013 represent payments to certain physicians, including residents, who provide professional services at VUMC inpatient locations as well as outpatient clinics. The expansion referenced in this project does not contemplate VUMC incurring additional physician's salaries and wages through growth of the resident program or through adding outpatient clinic locations. The professional services for the incremental patients treated in the proposed expansion will be provided primarily by Vanderbilt faculty who bill separately for their professional service through the Vanderbilt School of Medicine. Thus, the revenue associated with the faculty's professional service and related salaries and wages are excluded from the Projected Data Chart.

SUPPLEMENTAL

OTHER EXPENSES CATEGORIES		FY20	FY21
1.	General and Administrative	$19,090,537	$23,133,790
2.	Fringe Benefits	$5,501,532	$6,666,722
3.	Interest/ Lease	$4,962,167	$6,013,122
4.	Equipment	$4,361,475	$5,285,207
5.	Laundry and Housekeeping	$2,695,915	$3,266,893
6.	Plant Operations	$1,423,964	$1,725,550
7.	Other Expenses	$15,004,562	$18,182,432
	Total Other Expenses	**$53,040,152**	**$64,273,715**

4. **Section C, Economic Feasibility, Item 10**

The current assets and current liabilities are not listed in the provided Financial Documents. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. Please list the current assets and current liabilities for Vanderbilt University from the provided chart extracted from page 5 of the 2013 Financial Reports for Vanderbilt University.

RESPONSE: Please see the attached further breakout of Assets and Liabilities for Vanderbilt University and an estimated calculation of the current ratio of 1.71. From the attached Consolidated Statement of Financial Position, short term assets (STA) total $1,420,186,000 and short term liabilities (STL) total $829,369,000. Current ratio as defined as STA/ STL equals $1,420,186,000/ $829,369,000 or 1.71.

Vanderbilt University
Consolidated Statements of Financial Position
As of June 30, 2013 and 2012 (in thousands)

	2013	2012
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Cash and cash equivalents	$ 845,472 ①	$ 912,419
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Contributions receivable, net	70,302	72,334
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Total net assets	**5,339,319**	**5,019,548**
Total liabilities and net assets	**$ 7,605,896**	**$ 7,471,163**

The accompanying notes are an integral part of the consolidated financial statements.

*Cont. rec. due <1yr $ 32,285 ①
* current portion LTD $ 38,466 ②
ST Assets ① = 1,420,186
ST Liabilities ② = 829,369

current ratio: $\frac{STA}{STL} = \frac{1,420,186}{829,369} = 1.71$

COPY-
Clarification
SUPPLEMENTAL-2

Vanderbilt University Hospital
CN1406-021

VANDERBILT UNIVERSITY MEDICAL CENTER

Business Development

JUL 2 SUPPLEMENTAL

July 2, 2014

Phillip Earhart
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Dear Mr. Earhart:

Enclosed are an original and two copies of the letter from the commercial bank in response to your question in the second set of supplemental questions for Certificate of Need application number CN1406-021 for Vanderbilt University Hospitals.

Respectfully,

Ginna Felts

Ginna Felts
Business Development

3319 West End Avenue
Suite 920 Crystal Terrace
Nashville, TN 37203

www.mc.vanderbilt.edu

J.P.Morgan

July 1, 2014

Mr. Brett Sweet
Vice Chancellor for Finance and Chief Financial Officer
Vanderbilt University
321 Kirkland Hall
Nashville, TN 37240

RE: Vanderbilt University's Proposal Seeking State Certificate of Need for Approval of an Expansion to the Monroe Carell Jr. Children's Hospital at Vanderbilt and other hospital renovations (the "Project")

Dear Mr. Sweet:

You have advised J.P. Morgan Securities LLC ("J.P. Morgan") that The Vanderbilt University ("Vanderbilt" or the "University") may finance a portion of the above-referenced Project through bond financing (the "Bond Issue"). The borrower would be the University, a 501(c)(3) private not-for profit corporation. The debt would be issued through an appropriate conduit issuer. We understand that Vanderbilt will be applying for a Certificate of Need ("CON"). We understand that the amount to be financed will be approximately $70.8 million. For purposes of this letter, "J.P. Morgan" shall include any affiliate thereof.

Based upon the University's current financial strength, and assuming the continued credit quality of the University and the receipt of customary legal opinions and other documentation, J.P. Morgan would expect the University to be able to access the public debt markets, either on a tax exempt or taxable basis, and issue debt based upon the University's stand-alone credit ratings. The cost and terms of such a financing will depend on future market conditions, but we would expect access to be sufficient to achieve the necessary funding for the Project.

This letter is not intended to be, and shall not constitute, a commitment or undertaking to place or purchase or commit to place or purchase any bonds on a principal or agency basis, or a commitment or undertaking to provide or arrange or commit to provide or arrange any portion of the financing for the Project. Such obligations would arise only under separate written agreements acceptable to J.P. Morgan in its sole discretion. Furthermore, any such commitments would be subject to, among other things, (a) the satisfactory completion of J.P. Morgan's customary due diligence review; (b) approval by J.P. Morgan's internal committees; (c) the receipt of any necessary governmental, contractual, regulatory, Board of Trust or bondholders' consents or approvals in connection with the Project and the related Bond Issue; (d) the negotiation and documentation of the financing referred to above, including the terms and conditions of the Bond Issue, in form and substance satisfactory to J.P. Morgan and its counsel; (e) the receipt of bond ratings; (f) there not having occurred any material adverse change in the business, assets, operations, properties, condition (financial or otherwise), contingent liabilities, prospects or material agreements of the University; (g) there not having occurred any material adverse change in the legal or regulatory environment of the University; and (h) there not having occurred any disruption of or change in financial, banking or capital market conditions that, in

J.P.Morgan

J.P. Morgan's judgment, could make it inadvisable or impractical to proceed with the Bond Issue.

By accepting delivery of this letter, Vanderbilt agrees that this letter is intended solely for the use by the University and its representatives in connection with the CON approval of the Project, and will not be used for any other purpose, unless its is required to be disclosed by judicial or administrative process or in connection with any action, suit, proceeding, or claim or otherwise by applicable law. Neither Vanderbilt nor its representatives shall quote from, or summarize this letter or purport to describe, characterize or summarize the views of J.P. Morgan expressed herein without the prior consent of J.P. Morgan.

Neither J.P. Morgan nor any of its affiliates shall have any liability (whether direct or indirect or in contract, tort or otherwise) to Vanderbilt or any other person, including, without limitation, any of the University's bondholders, claiming through Vanderbilt University for or in connection with the delivery of this letter.

Sincerely,

J.P. Morgan Securities LLC

By:

Laura Powell

Laura Powell
Executive Director

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Vanderbilt University Hospitals

I, Ginna Felts, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Ginna Felts
CONSULTANT, BUSINESS DEVELOPMENT

Sworn to and subscribed before me, a Notary Public, this the 2nd day of July, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

Jennifer Hygrell
NOTARY PUBLIC

My commission expires May 5, 2015.

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

HF-0043

Revised 7/02

COPY-
Clarification
SUPPLEMENTAL-2

Vanderbilt University Hospital
CN1406-021

VANDERBILT UNIVERSITY MEDICAL CENTER

Business Development

June 30, 2014

Phillip Earhart
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Dear Mr. Earhart:

Enclosed are an original and two copies of a letter from Cecelia B. Moore, Associate Vice Chancellor of Finance, in response to question 1. Section C, Economic Feasibility, Item 2 in your second set of supplemental questions for Certificate of Need application number CN1406-021 for Vanderbilt University Hospitals.

Respectfully,

Ginna Felts

Ginna Felts
Business Development

3319 West End Avenue
Suite 920 Crystal Terrace
Nashville, TN 37203

www.mc.vanderbilt.edu

VANDERBILT UNIVERSITY MEDICAL CENTER

SUPPLEMENTAL

Cecelia B. Moore
Associate Vice Chancellor for Finance
Vanderbilt University Medical Center

June 29, 2014

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Andrew Jackson State Office Bldg.
Suite 850
500 Deaderick St.
Nashville, TN 37243

Dear Ms. Hill:

As indicated in our previous correspondence dated June 12, 2014, this letter confirms that Vanderbilt University by and through its Vanderbilt University Medical Center has financing resources sufficient to fund the project described in the Certificate of Need application. As outlined in our application and supporting documentation, it is anticipated that funding of the project will be provided through a combination of capital resources, including tax-exempt debt and cash reserves.

We will also provide a letter from one of our investment banking partners (JP Morgan Chase) indicating that a market exists for such tax-exempt debt. However, if such debt funding is not available, Vanderbilt could choose to fund the project through operating cash flows and cash reserves. As of June 30, 2013, current cash and unrestricted cash investments had a market value of $3 billion.

Sincerely,

Cecelia B. Moore

Cecelia B. Moore, MHA, CPA
Associate Vice Chancellor for Finance
Vanderbilt University Medical Center

3319 West End Avenue
Suite 700
Nashville, TN 37203-6840

tel 615.322.0084
www.finance.vanderbilt.edu

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Vanderbilt University Hospitals

I, Ginna Felts, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Ginna Felts
CONSULTANT, BUSINESS DEVELOPMENT

Sworn to and subscribed before me, a Notary Public, this the 30th day of June, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

Jennifer Hygrell
NOTARY PUBLIC

My commission expires May 5, 2015.

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

Saint Thomas Health

September 8, 2014

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: Vanderbilt University Hospitals
CN1406-021

Dear Ms. Hill:

This letter of opposition is submitted on behalf of Saint Thomas Midtown Hospital ("Midtown") and Saint Thomas West Hospital ("West"), to the above captioned certificate of need application filed by Vanderbilt University Hospitals ("Applicant") for the expansion and renovation of Vanderbilt University Hospital and Monroe Carell Jr. Children's Hospital, including the addition of 24 neonatal intensive care/pediatric intensive care beds, 23 obstetrical beds, and 61 adult acute care inpatient beds. The hospitals' opposition relates to the Applicant's request for these additional licensed beds.

Midtown is a major provider of obstetrical and NICU services, and Midtown and West are both major providers of acute care inpatient services in the Applicant's service area. The two hospitals are located .8 mile and 3.4 miles, respectively, from the Applicant.

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

General Comments

1. Utilization of hospital services is shifting from inpatient to outpatient care, even more so recently with implementation of the Affordable Care Act.

    a. The Applicant has acknowledged rapid growth in its own outpatient services.
    b. Therefore, future investments in inpatient services should be evaluated thoroughly.
    c. Agency rules allow "special consideration" for acute care bed expansion for specialty health service units in tertiary care regional referral hospitals. However, this discretion does not amount to an automatic blanket approval of such projects.

2. Despite population growth, the number of births in Tennessee has declined dramatically during the past five years, and this has had a negative impact on the demand for expanded OB, NICU and PICU services in particular. Therefore, the Applicant's statewide service area does not support its request for additional licensed beds.

    a. While the population in Tennessee grew 4.5% between 2008-2013 the number of births declined 6.5%. (See Exhibit 1.)
    b. Tennessee live birth rates between 2004-2013 declined 8.9%. (See Exhibit 2.)
    c. The overall number of low birth weight babies as a percentage of total births declined 1999-2013. (See Exhibit 3.)

3. Available bed capacity already exists within the Nashville tertiary hospitals:

    a. Official 2018 bed need projections show a surplus of 940 acute care beds in Davidson County and a surplus of 6,643 statewide. (See Exhibit 4.)
    b. The Applicant's proposed project will unnecessarily duplicate inpatient services already available in Nashville tertiary hospitals. (See Exhibit 5.)
    c. The Applicant has already been approved for two major bed expansion projects that have been delayed and are not yet fully implemented.
    d. A basic tenet of healthcare planning is that projects under development or newly developed should be given an opportunity to reach capacity before additional projects are approved.

OB/NICU/PICU

1. The Applicant provided no documentation to support its claims of projected increases in utilization.

2. The Applicant cited as the source for its projections an anonymous consulting company using a proprietary demand forecast.

3. The Applicant projects 2.9% annual growth in pediatric neonatal/critical care bed utilization, but this projected growth is inconsistent with historical declines throughout Tennessee, even with actual population increases across the State.

4. The Applicant has failed to provide a credible use rate analysis from reliable sources and, therefore, has failed to document a need for its expanded services.

5. Saint Thomas Midtown had an average of 31 empty OB beds in 2012 and 2013.

6. Saint Thomas Midtown had an average of 25 empty NICU beds from 2011 through 2013.

7. Centennial had an average of 17 empty NICU beds from 2011 through 2013.

8. Centennial had an average of 9 empty PICU beds in 2012 and 2013. (See Exhibit 5.)

Adult Med/Surg Beds

1. According to official Tennessee 2018 acute care bed need projections for Davidson County, there is a projected surplus of 940 beds based on licensed beds and a projected surplus of 315 beds based on set up and staffed (SUS) beds.

2. For the entire State, which the Applicant serves (and more), there is a projected surplus of 6,643 beds based on licensed beds and a projected surplus of 2,048 beds based on set up and staffed (SUS) beds.

3. Agency rules allow "special consideration" for acute care bed expansion for specialty health service units in tertiary care regional referral hospitals.

   However, adult med/surg beds are not a specialty unit. This discretion does not amount to an automatic blanket approval of such projects.

4. The four Nashville tertiary hospitals had a thousand empty beds from 2011 through 2013.

General Comments on Need

1. Volume projections on application page 26 and in the pro formas represent incremental volumes and dollars only. The baseline for existing beds and services (FY11 – FY13) has not been projected to FY20 or FY21. Without these baseline projections (and associated assumptions, methodology, etc.), it is impossible to determine the projected utilization for all the OB, NICU, PICU, observation and adult med/surg beds. Thus project need, reasonableness and adverse impact on existing providers cannot be determined.

2. Based on 2013 JAR data, the 95% Poisson probability bed need projects 100 NICU beds and 42 PICU beds without any population growth. There are no assumptions provided by the Applicant to allow an objective analysis to validate its projections to FY20 and FY21.

Accordingly, the Applicant's request for additional licensed beds should be denied.

Sincerely,

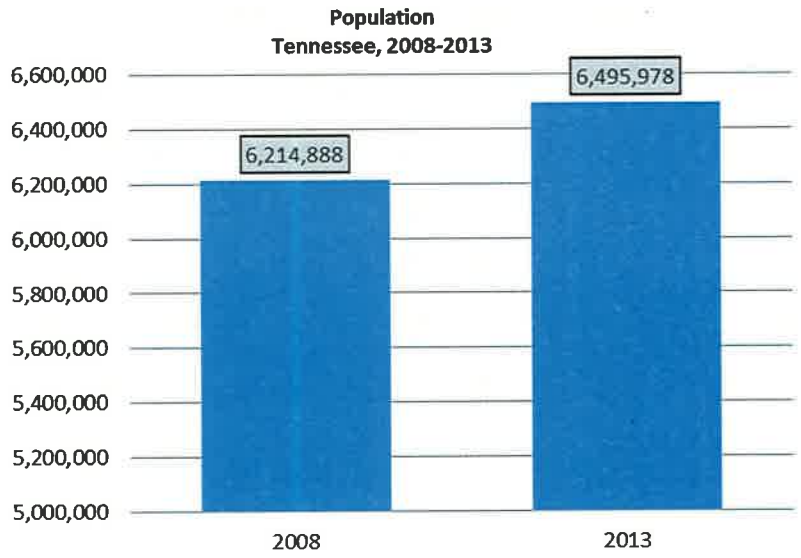
Blake Estes
Executive Director, Strategy & Planning

cc: Ginna Felts, Business Development
Vanderbilt University Medical Center

Exhibit 1

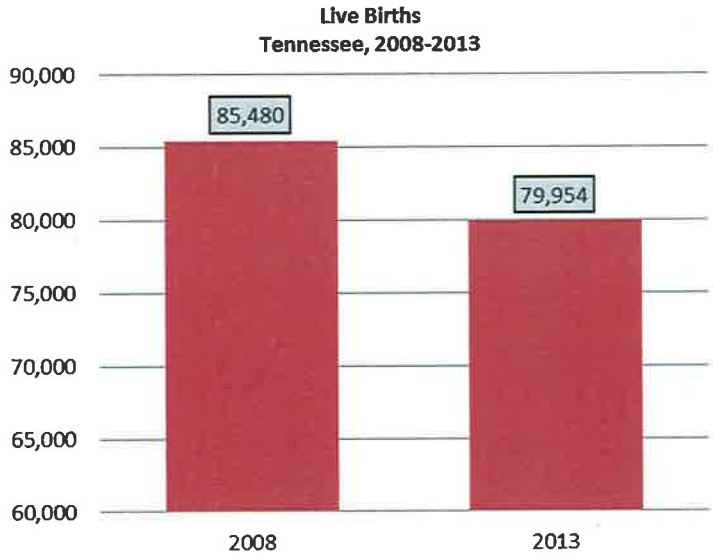
Trends in Population and Live Births
State of Tennessee, 2008-2013

The population increased
4.5% over the 5 year period



Source: Census.gov

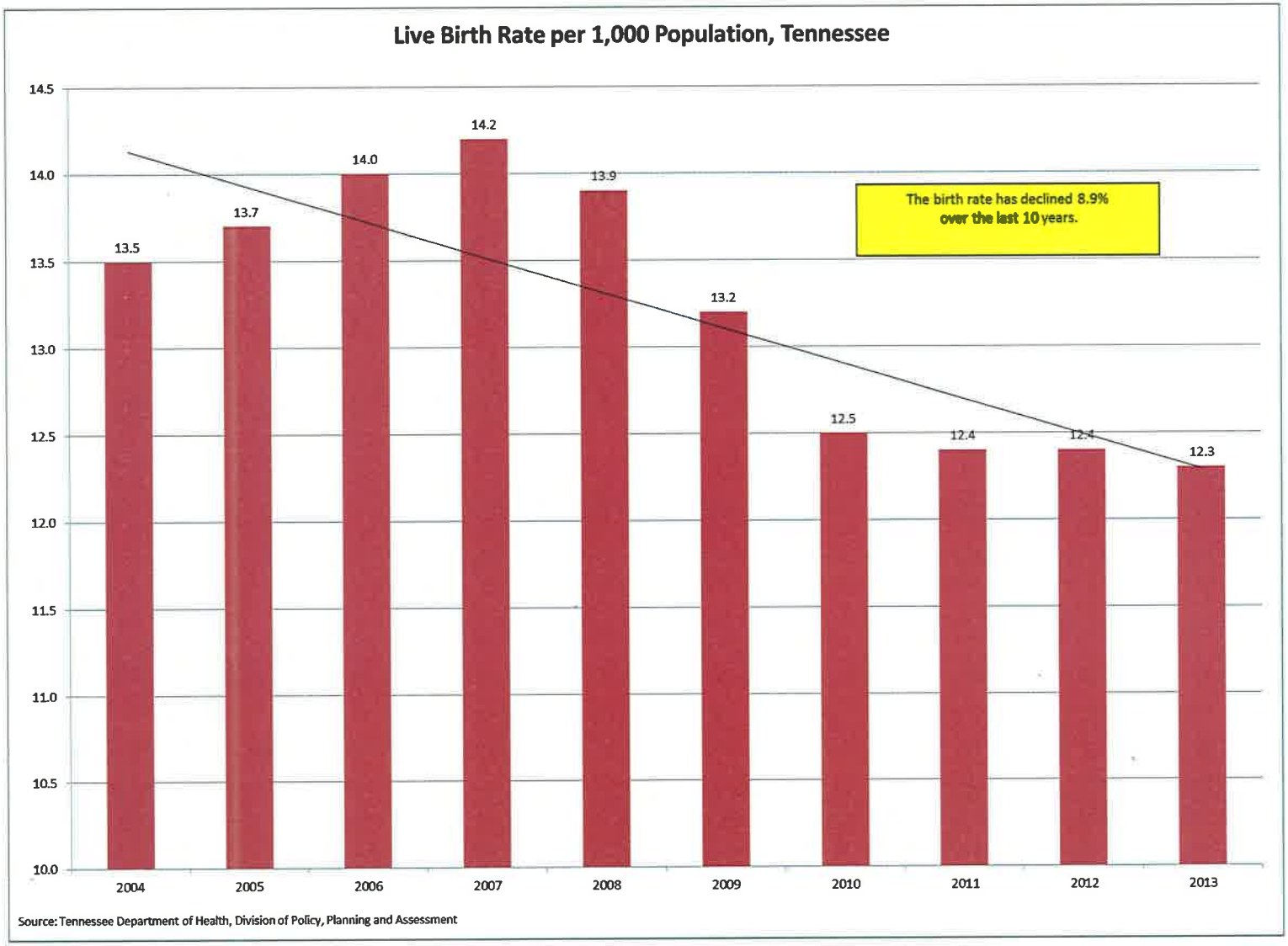
The number of births decreased
6.5% over the same 5 year period



Source: Tennessee Department of Health, Division of Policy, Planning and Assessment

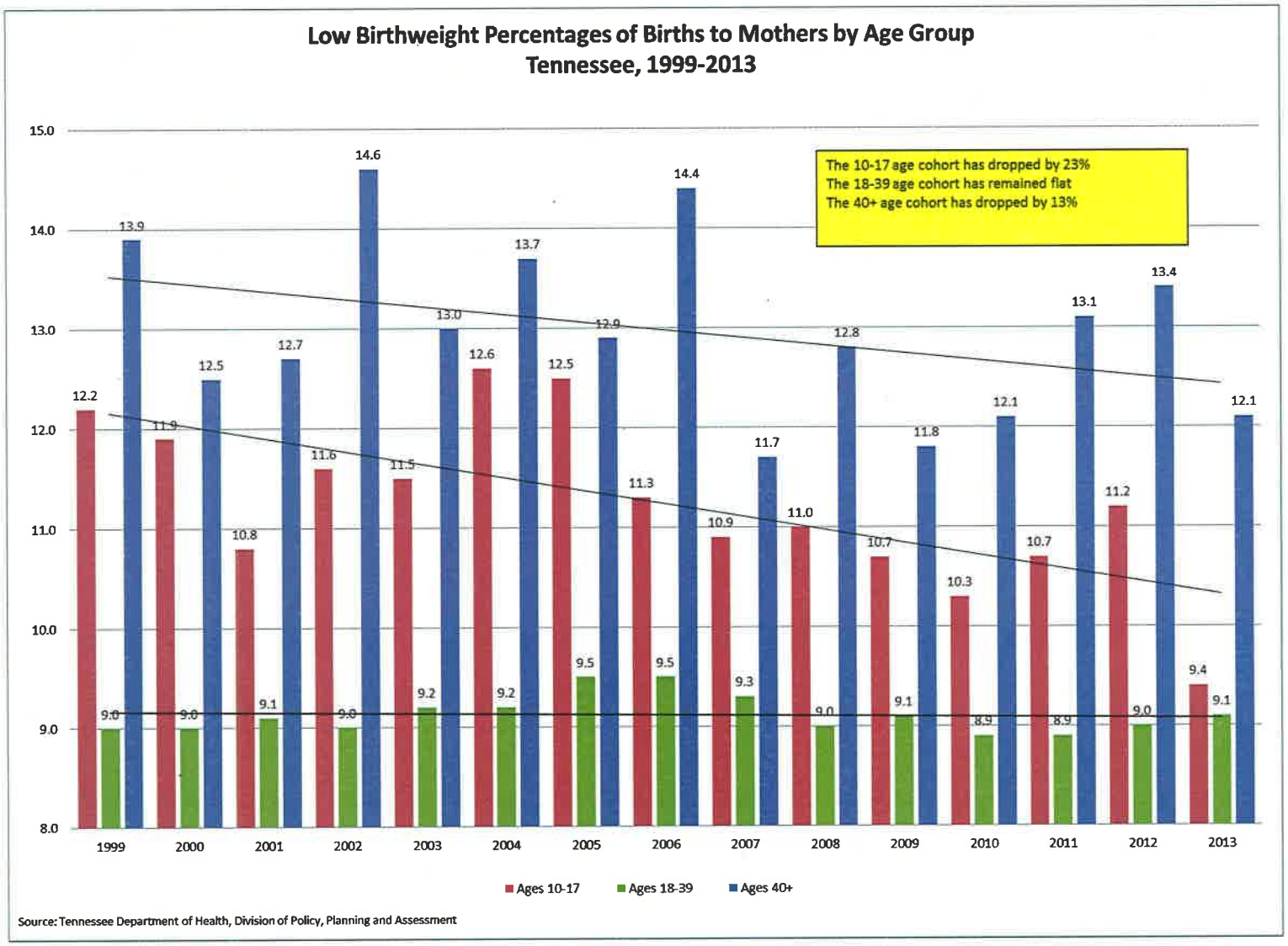
Saint Thomas Health

Exhibit 2



Saint Thomas Health

Exhibit 3



Saint Thomas Health

Exhibit 4

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS														
County	2012		Current	Service Area Population			Projected		Projected		2012 Actual Beds		Shortage/Surplus	
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	30	255	-133	-87
Beford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	6	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	2	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	2	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	30	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	35	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	12	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	6	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	11	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	12	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	1	12	-3	-3
Chester	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	8	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	3	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	7	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	21	159	-101	-46
Crockett	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	18	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-315
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	4	27	-23	-10
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	7	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	15	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	22	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	4	10	-40	-4
Fentress	0	0	0	-	-	-	-	-	-	-	8	54	-	-
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	15	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	20	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	9	81	-58	-44
Grainger	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	24	170	-141	-71
Grundy	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	30	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	1	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	5	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	5	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	5	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	6	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	4	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	14	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	1	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	2	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	2	25	-15	-15
Jackson	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	5	58	-21	-21
Johnson	51	0	1	233	232	232	0	1	0	1	2	2	-1	-1
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Lake	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lauderdale	3,044	8	15	4,293	4,252	4,218	8	15	8	15	2	25	-10	-10
Lawrence	9,298	26	37	18,503	18,540	18,545	26	37	26	37	9	80	-62	-43
Lewis	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lincoln	7,435	20	31	17,852	18,159	18,898	21	31	22	32	5	59	-27	-27

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Saint Thomas Health

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS														
County	2012		Current	Service Area Population			Projected		Projected		2012 Actual Beds		Shortage/Surplus	
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
McNairy	4,953	14	22	11,089	11,200	11,451	14	22	14	23	45	45	-22	-22
Macon	3,793	10	18	5,934	6,057	6,301	11	18	11	19	25	25	-6	-6
Madison	179,979	493	616	281,828	283,339	286,657	496	620	502	627	787	729	-160	-102
Marion	14,492	40	54	9,647	9,762	9,980	40	55	41	56	70	63	-14	-7
Marshall	675	2	5	1,895	1,911	1,956	2	5	2	5	25	12	-20	-7
Maury	42,096	115	144	102,509	102,974	104,036	116	145	117	146	255	215	-109	-69
Meigs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Montgomery	43,692	120	150	126,007	130,796	139,341	124	155	132	165	270	220	-105	-55
Moore	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Morgan	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Obion	10,628	29	42	20,715	20,637	20,560	29	42	29	41	173	85	-132	-44
Overton	16,555	45	61	21,794	22,030	22,558	46	62	47	63	114	82	-51	-19
Perry	6,000	16	26	5,114	5,146	5,192	17	26	17	26	53	25	-27	1
Pickett	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Polk	0	0	0	-	-	-	-	-	-	-	25	25	-	-
Putnam	61,949	170	212	105,866	108,424	113,926	174	217	183	228	247	243	-19	-15
Rhea	3,533	10	17	7,701	7,893	8,211	10	17	10	18	25	25	-7	-7
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Robertson	16,379	45	61	28,555	29,416	31,016	46	62	49	65	109	66	-44	-1
Rutherford	80,182	220	275	229,262	241,520	267,897	231	289	257	321	387	369	-66	-48
Scott	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sequatchie	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Shelby	934,049	2,559	3,199	1,416,974	1,430,639	1,457,026	2,584	3,230	2,631	3,289	4,177	3,115	-888	174
Smith	10,604	29	42	13,707	13,945	14,448	30	42	31	44	98	85	-54	-41
Stewart	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sullivan	242,753	665	831	417,761	423,735	435,560	675	843	693	867	1,056	769	-189	98
Sumner	48,799	134	167	115,476	119,215	126,486	138	173	146	183	303	213	-120	-30
Tipton	4,341	12	20	12,974	13,252	13,875	12	20	13	21	100	44	-79	-23
Trousdale	1,678	5	10	2,060	2,117	2,220	5	10	5	10	25	21	-15	-11
Unicoi	4,283	12	20	6,172	6,198	6,244	12	20	12	20	48	7	-28	13
Union	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Van Buren	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113
Tennessee									11,908	15,145	21,898	17,272	-6,643	-2,048

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics 11/14/2013
Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states

Saint Thomas Health

Exhibit 5

OB, NICU, PICU, Observation, and Total Bed Stats for Nashville Tertiary Hospitals, 2011 - 2013

	Vanderbilt University				Saint Thomas (West)				Baptist Hospital (Midtown)				TriStar Centennial				TOTAL			
	2011	2012	2013	2011-2013	2011	2012	2013	2011-2013	2011	2012	2013	2011-2013	2011	2012	2013	2011-2013	2011	2012	2013	2011-2013
OB	Level III								Level III				Level III							
Patients	4,251	4,686	5,025	18.2%	0	0	0	0.0%	6,728	6,379	5,960	-11.4%	2,613	3,041	3,212	22.9%	13,592	14,106	14,197	4.5%
Deliveries	3,751	4,164	4,479	19.4%	0	0	0	0.0%	6,734	6,406	5,990	-11.0%	2,568	3,041	3,212	25.1%	13,053	13,611	13,681	4.8%
Infants Born Alive	3,843	4,246	4,554	18.5%	0	0	0	0.0%	6,876	6,522	6,092	-11.4%	2,568	2,998	3,137	22.2%	13,287	13,766	13,783	3.7%
LDR Beds	12	12	12	0.0%	0	0	0	0.0%	22	22	22	0.0%	12	12	12	0.0%	46	46	46	0.0%
Postpartum Beds	32	32	32	0.0%	0	0	0	0.0%	63	63	63	0.0%	25	25	25	0.0%	120	120	120	0.0%
Admissions*	4,272	4,725	5,079	18.9%	0	0	0	0.0%	7,298	6,885	6,483	-11.2%	3,002	3,439	3,593	19.7%	14,572	15,049	15,155	4.0%
Inpatient Days*	12,608	14,110	15,184	20.4%	0	0	0	0.0%	21,432	19,558	19,824	-7.5%	10,126	11,496	11,231	10.9%	44,166	45,164	46,239	4.7%
ADC	34.5	38.6	41.6	20.6%	0.0	0.0	0.0	0.0%	58.7	53.4	54.3	-7.5%	27.7	31.4	30.8	11.2%	121.0	123.4	126.7	4.7%
Occupancy	78.4%	87.7%	94.5%	20.5%	0.0%	0.0%	0.0%	0.0%	69.1%	62.8%	63.9%	-7.5%	74.9%	84.9%	83.2%	11.1%	72.9%	74.3%	76.3%	4.7%
Available Beds	10	5	2		0	0	0		26	32	31		9	6	6		45	43	39	
NICU	Level III C**				N/A				Level III B				Combined Level II B & Level III C**							
Discharges	948	1,669	1,087	14.7%	0	0	0	0.0%	433	439	475	9.7%	0	1,436	662	0.0%	1,381	3,544	2,224	61.0%
Patient Days	25,666	29,611	30,669	19.5%	0	0	0	0.0%	9,747	9,353	10,041	3.0%	13,053	15,446	17,929	37.4%	48,466	54,410	58,639	21.0%
ALOS	27.1	17.7	28.2	4.1%	0	0	0	0.0%	22.5	21.3	21.1	-6.2%	0	10.8	27.1	0.0%	35.1	15.4	26.4	-24.8%
ADC	70.3	80.9	84	19.5%	0	0	0	0.0%	26.7	25.6	27.5	3.0%	35.8	42.2	49.1	37.2%	132.8	148.7	160.7	21.0%
Bassinets	83	100	100	20.5%	0	0	0	0.0%	52	52	52	0.0%	60	60	60	0.0%	195	212	212	8.7%
Occupancy	84.7%	80.9%	84.0%	-0.8%	0	0	0	0.0%	51.3%	49.2%	52.9%	3.1%	59.7%	70.3%	81.8%	37.0%	68.1%	70.1%	75.8%	11.3%
Available Beds	13	19	16		0	0	0		25	26	24		24	18	11		62	63	51	
PICU																				
Patients	494	694	783	58.5%	0	0	0	0.0%	0	0	0	0.0%	0	20	280	0.0%	494	714	1,063	115.2%
Patient Days	11,279	10,075	11,708	3.8%	0	0	0	0.0%	0	0	0	0.0%	0	38	586	0.0%	11,279	10,113	12,294	9.0%
ALOS	22.8	14.5	15	-34.2%	0	0	0	0.0%	0	0	0	0.0%	0	1.9	2.1	0.0%	22.8	14.2	11.6	-49.1%
ADC	30.9	27.5	32.1	3.9%	0	0	0	0.0%	0	0	0	0.0%	0	0.1	1.6	0.0%	30.9	27.6	33.7	9.1%
Beds	36	42	42	16.7%	0	0	0	0.0%	0	0	0	0.0%	0	10	10	0.0%	36	52	52	44.4%
Occupancy	85.8%	65.5%	76.4%	-11.0%	0	0	0	0.0%	0	0	0	0.0%	0.0%	1.0%	16.0%	0.0%	85.8%	53.1%	64.8%	-24.5%
Available Beds	5	15	10		0	0	0		0	0	0		0	10	8		5	24	18	
Observation																				
Outpatients	9,635	12,256	10,750	11.6%	5,022	4,998	4,831	-3.8%	5,375	5,617	5,785	7.6%	6,085	5,890	5,452	-10.4%	26,117	28,761	26,818	2.7%
ADC	26.4	33.5	29.5	11.7%	13.8	13.7	13.2	-4.3%	14.7	15.3	15.8	7.5%	16.7	16.1	14.9	-10.8%	71.6	78.6	73.5	2.7%
Dedicated Beds	0	0	0	0.0%	0	0	0	0.0%	0	0	30	N/A	0	0	0	0.0%	0	0	30	N/A
Non Dedicated Beds	0	0	0	0.0%	381	381	381	0.0%	408	377	222	-45.6%	193	193	193	0.0%	982	951	796	-18.9%
Total Beds																				
Licensed	916	985	1,019	11.2%	541	541	541	0.0%	683	683	683	0.0%	606	657	657	8.4%	2,746	2,866	2,900	5.6%
SUS	909	966	982	8.0%	396	404	404	2.0%	453	453	432	-4.6%	584	630	650	11.3%	2,342	2,453	2,468	5.4%
Not Staffed	0	0	0	0.0%	98	137	137	39.8%	230	230	251	9.1%	26	26	11	-57.7%	354	393	399	12.7%
ADC	798	773	862	8.0%	272	265	291	7.0%	253	260	263	4.0%	382	407	427	11.8%	1,705	1,705	1,843	8.1%
Occup-Lic	87.1%	78.5%	84.6%	-2.9%	50.3%	49.0%	53.8%	7.0%	37.0%	38.1%	38.5%	4.1%	63.0%	61.9%	65.0%	3.2%	62.1%	59.5%	63.6%	2.4%
Occup-SUS	87.8%	80.0%	87.8%	0.0%	68.7%	65.6%	72.0%	4.8%	55.8%	57.4%	60.9%	9.1%	65.4%	64.6%	65.7%	0.5%	72.8%	69.5%	74.7%	2.6%
Inpatient Days	275,500	275,013	298,505	8.4%	102,534	100,202	99,877	-2.6%	113,135	112,163	110,408	-2.4%	139,114	147,903	156,094	12.2%	630,283	635,281	664,884	5.5%
Inpatient ADC	754.8	751.4	817.8	8.3%	280.9	273.8	273.6	-2.6%	310	306.5	302.5	-2.4%	381.1	404.1	427.7	12.2%	1,726.8	1,735.7	1,821.6	5.5%
Observation ADC	26.4	33.5	29.5	11.7%	13.8	13.7	13.2	-4.3%	14.7	15.3	15.8	7.5%	16.7	16.1	14.9	-10.8%	71.6	78.6	73.5	2.7%
Total ADC	781.2	784.9	847.3	8.5%	294.7	287.5	286.8	-2.7%	324.7	321.8	318.3	-2.0%	397.8	420.2	442.6	11.3%	1,798.4	1,814.3	1,895.1	5.4%
Occup-Lic	85.3%	79.7%	83.2%	-2.5%	54.5%	53.1%	53.0%	-2.8%	47.5%	47.1%	46.6%	-1.9%	65.6%	64.0%	67.4%	2.7%	65.5%	63.3%	65.3%	-0.3%
Occup-SUS	85.9%	81.3%	86.3%	0.5%	74.4%	71.2%	71.0%	-4.6%	71.7%	71.0%	73.7%	2.8%	68.1%	66.7%	68.1%	0.0%	76.8%	74.0%	76.8%	0.0%
Available Beds	135	200	172		246	254	254		358	361	365		208	237	214		948	1,052	1,005	

* MDC 14 - Pregnancy, Childbirth, & The Puerperium

** Form Does Not Allow Level IV Source: Tennessee Department of Health

Joint Annual Reports, 2011 - 2013

Saint Thomas Health

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before June 9 (Month / day), 2014 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Vanderbilt University Hospitals (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Vanderbilt University with an ownership type of not-for-profit

and to be managed by: Vanderbilt University Hospitals intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]: the expansion and renovation of various existing facilities on its campus at 1211 Medical Center Drive, Nashville, Tennessee, including the build out of three previously approved floors at Monroe Carell Jr. Children's Hospital at Vanderbilt ("MCJCHV") to accommodate (1) the relocation of the obstetrical program, the newborn nursery and the neonatal unit currently located in Vanderbilt University Hospital ("VUH") to MCJCHV; (2) the addition of 23 obstetrical beds; and (3) the addition of 24 neonatal/ pediatric critical care beds. The space vacated in VUH due to relocations to MCJCHV will be renovated to accommodate the addition of 61 adult acute care inpatient beds. Other areas in VUH will be renovated to accommodate a total of 63 observation beds. The project will require approximately 79,783 square feet of renovation, 126,686 square feet of new construction, and will increase the total licensed bed number by 108. The project does not involve the initiation of new health care services or acquisition of major medical equipment The estimated project cost is $118,276,950.

The anticipated date of filing the application is: June 12, 2014

The contact person for this project is Ginna Felts (Contact Name) Business Development (Title)

who may be reached at: Vanderbilt University Medical Center (Company Name) 3319 West End Avenue, Suite 920 (Address)

Nashville (City) TN (State) 37203 (Zip Code) 615/936-6005 (Area Code / Phone Number)

Ginna Felts (Signature) 6.9.14 (Date) Ginna.rader@vanderbilt.edu (E-mail Address)

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: August 31, 2014

APPLICANT: Vanderbilt University Hospitals
1211 Medical Center Drive
Nashville, Tennessee 37203

CN1406-021

CONTACT PERSON: Ginna Felts, Business Development
3319 West End Avenue, Suite 920
Nashville, Tennessee 37203

COST: $118,276,950

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

The applicant, Vanderbilt University Hospitals, located in Nashville (Davidson County), Tennessee, seeks Certificate of Need (CON) approval for the expansion and renovation of various existing facilities on its campus at 1211 Medical Center Drive, including the build out of three previously approved floors at Monroe Carell, Jr. Children's Hospital at Vanderbilt (MCJCHV) to accommodate (1) the relocation of the obstetrical program, the newborn nursery, and the neonatal unit currently located in Vanderbilt University Hospital (VUH) to MCJCHV; (2) the addition of 23 obstetrical beds; and (3) the addition of 24 neonatal/critical care beds. The space vacated in VUH due to relocations to MCJCHV will be renovated to accommodate the addition of 61 adult acute care beds. Other areas in VHS will be renovated to accommodate a total of 63 observations beds. The project will require approximately 79,783 square feet of renovation, 126,686 square feet of new construction, and will increase the licensed bed compliment by 108. The project does not involve the initiation of new health care services or acquisition of major medical equipment.

The project's total construction cost will be $77,126,075 for the renovated space and new construction at a square foot cost of $373.52; which is higher than approved projects for 2010-2012.

The applicant provides an organizational chart and ownership list in Attachment A.4.

The total estimated cost of the project is $118,276,950 and will be financed with generated or borrowed funds to ensure adequate funds will be available for the project at a reasonable cost. At Vanderbilt's discretion, financing for part of the cost may be obtained from public securities. See attachment C, Economic Feasibility 2 in Supplemental 2.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:

The applicant's designated service area population projections are listed in the following table:

Tennessee Service Area Total Population Projections
2014 and 2018 and Acute Care Licensed Bed Need/Surplus

County	2014 Population	2018 Population	% Increase or (Decrease)	Licensed Bed Need/Surplus
Bedford	47,368	50,566	6.8%	-27
Cannon	14,125	14,540	2.9%	-31
Cheatham	39,853	40,765	2.3%	-3
Clay	7,702	7,673	-0.4%	-12
Coffee	54,273	56,841	4.7%	-101
Cumberland	57,815	60,292	4.3%	-108
Davidson	656,385	682,330	4.0%	-940
DeKalb	18,952	19,125	0.9%	-52
Dickson	50,860	51,964	2.2%	-90
Fentress	18,404	18,987	3.2%	n/a
Franklin	41,230	42,122	2.2%	-71
Giles	29,315	29,285	-0.1%	-58
Grundy	13,355	13,293	-0.5%	n/a
Hickman	24,422	24,698	1.1%	-11
Houston	8,388	8,447	0.7%	-10
Humphreys	18,498	18,561	0.3%	-15
Jackson	11,368	11,495	1.1%	n/a
Lawrence	42,329	42,387	0.1%	-62
Lewis	12,112	12,224	0.9%	n/a
Lincoln	34,281	35,697	4.1%	-27
Macon	23,188	24,121	4.0%	-6
Marshall	31,286	32,015	2.3%	-20
Maury	82,280	83,256	1.2%	-109
Montgomery	187,649	200,561	6.9%	-105
Moore	6,350	6,401	0.8%	n/a
Overton	22,489	22,967	2.1%	-51
Perry	8,014	8,096	1.0%	-27
Pickett	5,019	4,943	-1.5%	n/a
Putnam	77,024	82,623	7.3%	-19
Robertson	70,391	74,371	5.7%	-44
Rutherford	293,582	329,446	12.2%	-66
Smith	19,618	20,281	3.4%	-54
Stewart	13,549	13,941	2.9%	n/a
Sumner	172,262	183,406	6.5%	-120
Trousdale	8,167	8,582	5.1%	-15
Van Buren	5,450	5,474	0.4%	n/a
Warren	40,489	41,155	1.6%	-79
Wayne	16,854	16,724	-0.8%	-69
White	26,871	27,974	4.1%	-29
Williamson	202,923	223,333	10.1%	-64
Wilson	124,073	133,357	7.5%	-113
Total	**2,638,563**	**2,784,319**	**5.5%**	**-2,608**

Source: *Tennessee Population Projections 2000-2020, 2013 Revision*, and *2012 Joint Annual Report of Hospitals* ,Tennessee Department of Health, Division of Health Statistics

There is a surplus in the applicant's designated service area of 2,608 acute care beds. The following pages illustrate the occupancy of service area hospitals. In addition, no hospital in the applicant's service area has 80% occupancy.

The Joint Annual Report of Hospitals occupancy rates for the applicant's service area are located on the following pages.

Vanderbilt's master planning process has identified areas of need that necessitate the expansion and renovations of their existing facility by increasing their bed compliment by 108 beds for a total of 1,159 beds. The following components are included in the project are:

- Build out of three shelled bed floors approved in the MCJCHV expansion (CON0710-075). Two floors will include the obstetrical program relocated from VUH as well as an additional 23 obstetrical beds (+21 antepartum/postpartum and +2 labor and delivery rooms (LDRs). In addition, two C-section rooms will be relocated and one C-section room will be added. The normal newborn nursery will be relocated from VUH.

- One floor will included the addition of 22 neonatal/pediatric critical care beds and the relocation of the Stahlman 16-bed neonatal unit from the 4th floor at VUH.

- Renovation of the vacated obstetrical space in VUH will be backfilled with 61 adult acute care inpatient beds.

- Addition of three observation units on the VUMC campus will house 63 observation beds.

The applicant provides a detailed floor by floor description of the project on pages 5, 6, and 7 of the application.

According to the applicant, the increase in inpatient and observation beds is necessary due to the consistently high occupancy at both VUH and MCJCHV and the future growth as patients continue to access the subspecialty care available at VUMC. As a major referral hospital serving Tennessee and the Southeast, high utilization continues to tax the capacity of the existing hospitals.

- Vanderbilt is in high demand for adult and pediatric acute clinical care services due to their expertise and the specialties offered at VUMC. VUMC has the only Level 1 Trauma Center, Level 4 Neonatal Intensive Care Unit, dedicated Burn Center, comprehensive transplant program, and NCI-designated Comprehensive Cancer Center in the State serving adults and children.

- In 2013, VUH had eleven adult patient care specialties ranked in the U.S. News and World Report's annual rankings. As a result of quality services and expertise of faculty, occupancy at VUH has consistently been above 90%. In addition, overuse of the emergency room has increased demand for beds at VUH.

- MCJCHV is the region's only comprehensive pediatric health care provider. MCJCHV continues to receive national recognition for its exception patient care. In 2013, MCJCHV was named among the top pediatric health care providers in the U. S. News and World Report's annual Best Children's Hospitals rankings; nine of its pediatric specialty programs were recognized. MCJCHV has received national recognition from Parent's Magazines and Children's Hospital Association.

- The obstetrical program at VUMV has experienced tremendous growth over the last five years. Deliveries at VUH have increased 80% from 2,500 deliveries in 2008, to over 4,500 in 2014. The demand has been escalated by the high quality maternal fetal medicine program at VUH and the multiple obstetrical specialty clinics including The Fetal Center at Vanderbilt, the Comprehensive Care Clinic (HIV/AIDS medical clinic) the Diabetes Clinic, the Congenital Heart Disease Clinic for Pregnant Women, and the Bariatric Obstetric Clinic. These specialty clinics draw patients from Middle Tennessee and beyond to the medical specialties at VUH.

MCJCHV commissioned a proprietary study by a globally respected healthcare consulting firm that indicated additional neonatal/critical care capacity is need due to the following reasons:

- Increased demand from high utilization demographic groups;
- Increased utilization due to the improving economy and an increase in higher risk birth due to higher occurrences of maternal obesity and diabetes;
- Increase in ALOS due to the increase in fertility treatments that lead to multiples and premature births, more woman inducing early, and enhanced technologies to keep younger babies alive.

The propriety study used a 2.9% neonatal growth rate per year while MCJCHV has experienced a 3.8% annual growth rate over the last seven years.

Obstetrical demand is twofold. The obstetrical unit at VUH is currently running at 84% capacity. This is considered less than ideal for high quality care. To ensure a 95% confidence level regarding beds needed when patient arrive unplanned/unscheduled, it is vital a unit has a target occupancy of 75%. Additionally, with the move to MCJCHV, triage will occur in the inpatient beds, resulting in the need for additional obstetrical beds.

The continued growth in maternal fetal medicine and the complex subspecialty prenatal care provided, coupled with the minimal 1% growth rate forecasted support the obstetrical volumes projected. MCJCHV is one of three hospitals in the country that performs fetal surgery and it is anticipated that additional high-risk antepartum beds will be needed.

The following chart was provided by the applicant and portrays the changes in bed assignments after the completion of the project.

Bed Type	Current Bed Assignment	Proposed Bed Assignment	+/-
Med/Surg	443	504	61
Obstetrical	50	73	23
ICU/CCU/(+PICU)	241	265	24
Neonatal	100	100	n/a
Pediatric	129	129	n/a
Psychiatric	88	88	n/a
Total	**1,051**	**1,159**	**108**

TENNCARE/MEDICARE ACCESS:
The applicant participates in the Medicare and TennCare/Medicaid programs. The applicant has contracts with AmeriGroup, United HealthCare Community Plan. ValueOptions, and BlueCare.

In year one of the completed project, the applicant projects Medicare revenues of $141,433,114 or 27% of gross revenues and TennCare revenues of $105,933,190 or 20% of gross revenues. Charity care is anticipated to be $41,803,738 or 8% of gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located in the application on page 28. The total project cost is $118,276,950.

Historical Data Chart: The Historical Data Chart is located on page 43 of Supplemental 1. The applicant reported occupancy of 82.3%, 81.2%, and 81.0% in 2011, 2012, and 2013, respectively. The applicant reported net operating revenues of $102,795,178, $104,181,348, and ($23,201,131), each year, respectively.

Projected Data Chart: The Projected Data Chart for is located on page 5 of Supplemental 2. The applicant projects 6,508 and 7,957 discharges in years one and two, respectively. The total net operating revenue in year one is projected to be $35,819,903 and $42,042,719 in year two of the project.

The average gross charge for the project is $80,944 while the average net revenue per case is $25,441.

The applicant considered several construction alternatives, one of which involved the vertical expansion of the Vanderbilt Clinic building. The expense of this option was considered an inefficient use of funds given the limited number of beds and programmatic components needed.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant provides a listing of all existing health care providers in Attachment C., Orderly Development of Healthcare 1.

Vanderbilt projects the staffing for this project to be 242.0 FTE registered nurses, 38.0 FTE medical receptionists, and 62.0 FTE care partners.

Vanderbilt University Medical Center has accredited training programs in medicine, nursing, pharmacy, respiratory therapy, dietetics, medical technology, radiation therapy technology, cardiovascular perfusion technology, and nuclear medicine technology. Vanderbilt University Medical Center is the major clinical training facility for Vanderbilt University Medical School.

Additionally, the applicant reports the Department of Radiology provides clinical training for students from Vanderbilt University Hospital Nuclear Medicine Technology Program, the Vanderbilt University Hospital Diagnostic Sonography Program, Volunteer State Community College Radiologic Technology Program, Austin Peay University Radiologic Technology Program, Metropolitan General Radiologic Technology Program, and the Southern Illinois University Radiologic Program.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited the Joint Commission.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   The applicant states the beds, services, and medical equipment will be constructed to meet all applicable standards.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

   These criteria are not applicable.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

   The proposed project is in response to the current high inpatient and observation case volumes and projections for future growth due to patients accessing the subspecialty care at VUMC. Patients from an extended service area, including out of state patients utilize the facility.

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{\text{365 (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

   a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

   b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \times \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

$$\text{Projected Need} = \text{Projected ADC} + 2.33 \times \sqrt{\text{Projected ADC}}$$

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

There is a surplus in the applicant's designated service area of 2,608 acute care beds. In addition, no hospital in the applicant's service area has 80% occupancy.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

No hospital in the service area has an 80% occupancy or greater. VUMC maintains their daily occupancy is consistently higher that 90%. MCJCHV reports their average daily occupancy is over 80%.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

Outstanding projects include MCJCHV CN0710-075, VUMC CN0606-037, and Summit Medical Center CN1402-004.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

The applicant requests special consideration for the additional acute care beds proposed in the application due to the fact VUMC is a tertiary care regional referral hospital, providing tertiary and quaternary care to patients in Tennessee and throughout the Southeast. Vanderbilt is in high demand for adult and pediatric acute clinical care services due to their expertise and the specialties offered at VUMC. VUMC has the only Level 1 Trauma Center, Level 4 Neonatal Intensive Care Unit, dedicated Burn Center, comprehensive transplant program, and NCI-designated Comprehensive Cancer Center in the State serving adults and children. More than 25% of VUMV patient are from outside the primary service area.